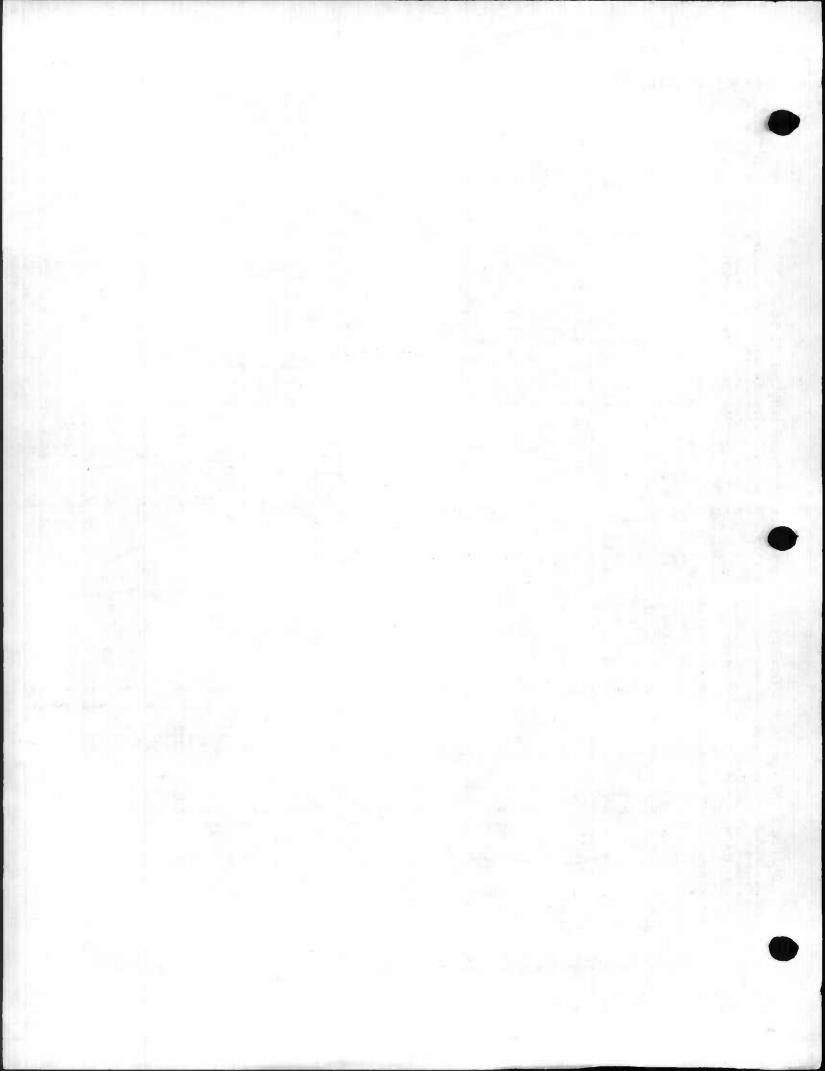
State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Smith 99 Car 2 21:23 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Months Days Hours Min. Month, Day, Year) Maryland Medical System of Baltimore City University 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** 1 M 2 □ F Yrs. **Director** 214-18-7647 27, 1922 Maryland Jan. Usual Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo Maryland N/A Baltimore 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? 1914 Deering Avenue 21230 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. 1 Never Merried 2 Merried 1 XYes 2 No Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Mfg. Glass Maker permit. Pages 1 and 2 should be file Department of Health and Mental Hy important. If them 27 is marked other any injury or other treumetic event. 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl E. Smith Sarah Fritze 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melba G. Smith / Wife 1914 Deering Avenue, Baltimore, Maryland 21230 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 3/1/99 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediete Cause (Finel disease or condition resulting in deeth) 15chem Examiner Examine tallare physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in daath) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): 98 the attending P.0. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown abelominal gortic aneurysm Records, é 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No this 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral edical Certification: 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examine on end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29c. License number 29b. Signatura and title of certific 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of seath (Item 23a) (Type, Print) Banks University of Maryland State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Elva Ellsworth Smith March 3, 1999 8:40 AM /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Catonsville Commons Catonsville Baltimore If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Funeral 1 M 2 F Yrs 93 Director 216-50-1061 11, 1906 Maryland Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 106 Chalmers Avenue 21061 USA Funeral 12. Was Dacedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian, Black, Whita, atc. 1 □ Navar Married 2 □ Married 1 ☐ Yas 2 No ρ Specify: 3 ₩ Widowad 4 Divorcad White Completed 15. Dacedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens. Important: If flem 27 is marked other than any injury or other branes. Elamantary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Ownhome 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) George Washington Rush Clara Daughtery 2 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Paul O. Smith / Son 106 Chalmers Avenue, Glen Burnie, Maryland 21061 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Spacify) Meadowridge Memorial Park 3/5/99 Elkridge, Maryland 21. Signature of Funeral Sarvica Ligensaa 22. Nama and Addrass of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata interval Batw **Physician** /Medical Immediata Causa (Final erebovasulor Acc. Del disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting in death) Last Due to (or as a consequence of) Physician/Medical Dua to (or as a consequanca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Cerchiorsal Acciont 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 1 No 1 Yas 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) To 1 Yas 2 No Othar: 4 Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. injury at Work? 1 Matural 5 Panding Invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida

P.O. Box 68760. Records. Division of Vital

sician end buriel-trensit attending physician for use es the burle been signed by the should be detached certificate After this To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: A/ by

T is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at

the Maryla

Smith

Baltimore.

State Registrar

Medical

29a. Certifiar

(Check only

1 Certifying Phyalcien: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

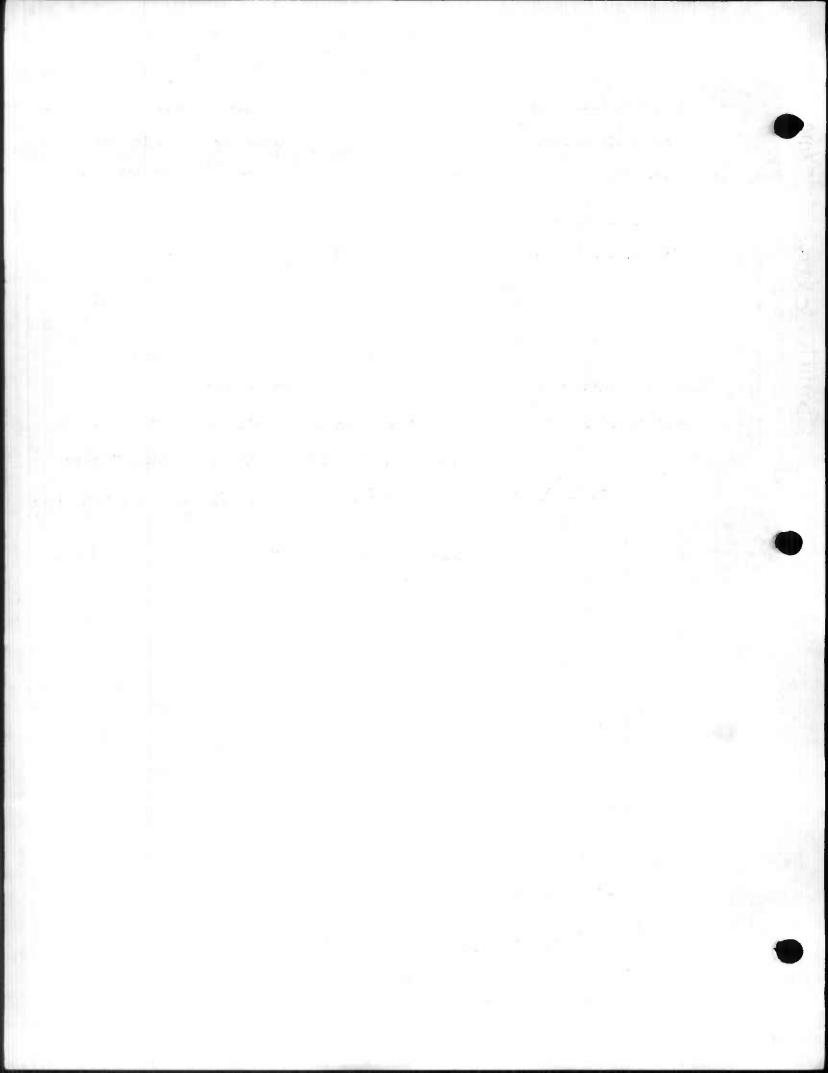
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and titla of certifiar Kunz

29c. Licansa number

29d. Data signed (Month, Day, Year)

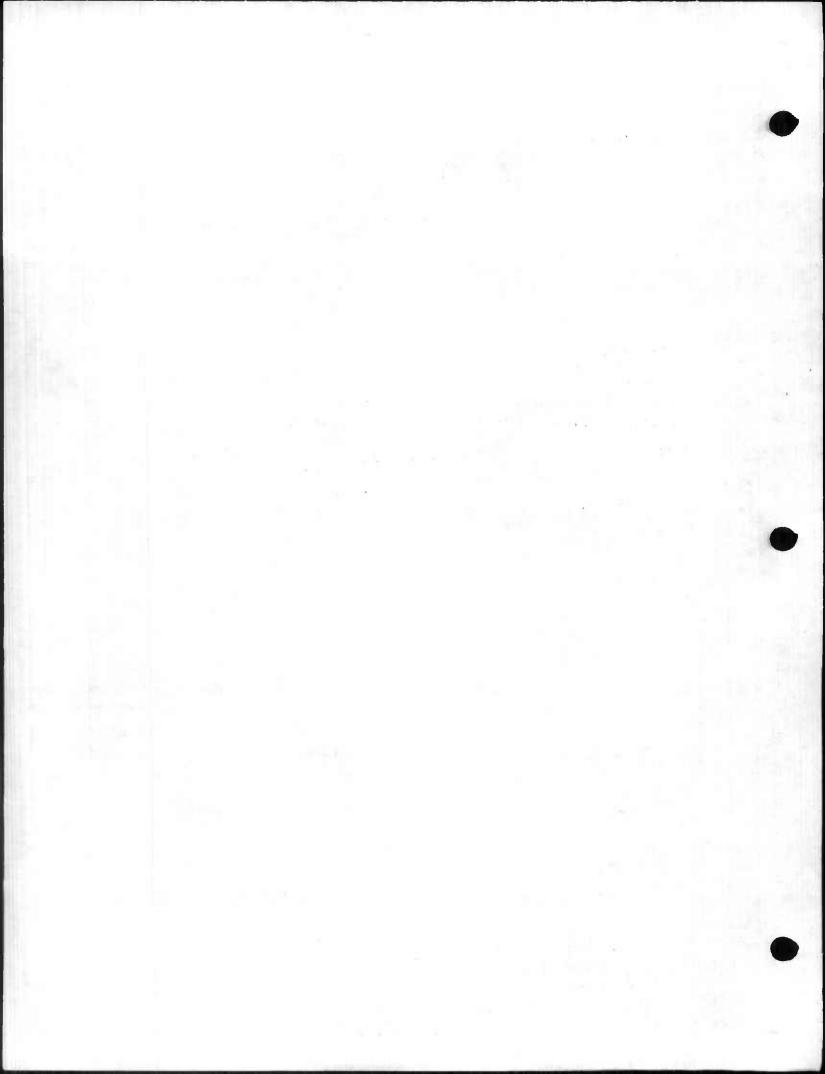
30. Nama and addrass of parson who completed cause of death (Itam 23a) (Type, Print)

2. Registrar's Signature

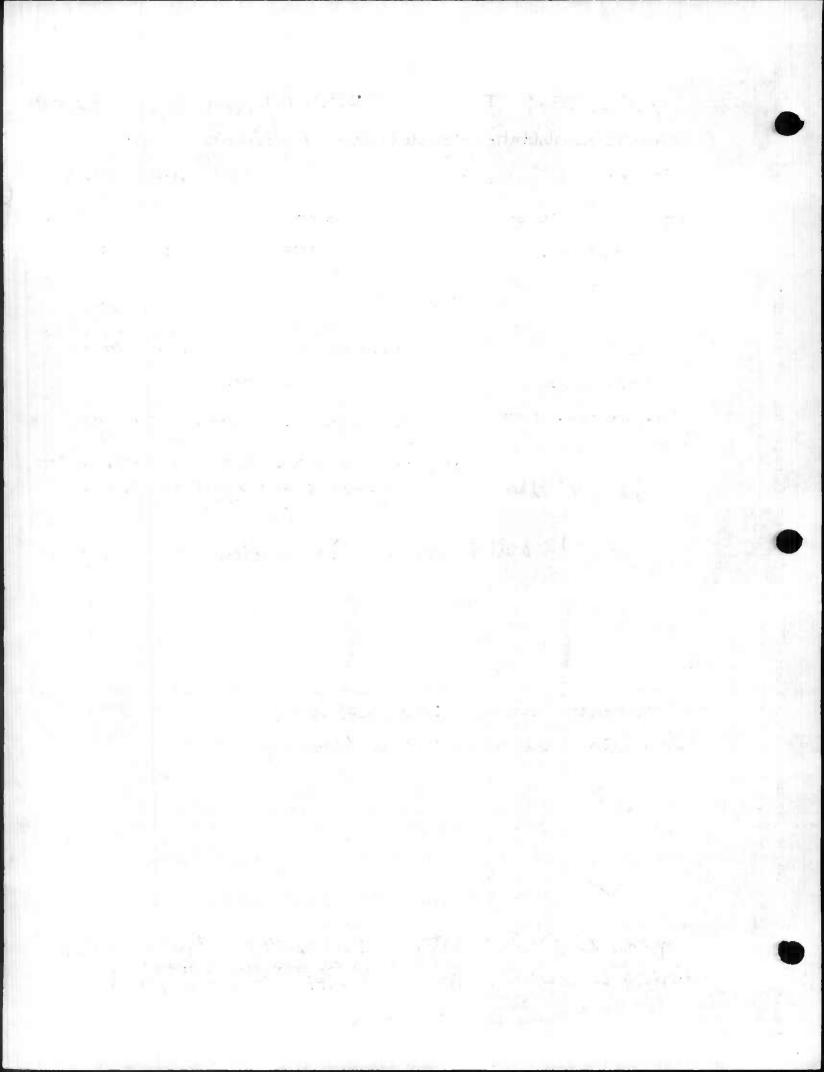


State of Maryland / Department of Health and Mental Hygiene

			Cer	tificate of	Death	R	eg. No.	U	1003			
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/Medical	0.1.0.1.0.0.0	V. Shelto	on			-di			1:30an			
Examiner	4a Facility Name (If not Institution, give 2610 Hallam Co				4b. City, Town, or L Baltimo	ore	4c. County o	of Death				
Funeral Director	5. Social Security Number 220-36-8829 1	7. Aga (In yr.	s. lest birthday) Yrs.	ff Under 1 Yea Months Days		8. Date of Birth	-41 -211	9. Birthpl Count	ace (Steta or Fora ry) MD			
p .	Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	cation				10	M Incide City Limi			
Aaryla Por		100.0	Baltin									
288-1	MD NA		Daiti	10f. Zip Code			0a. Citizen of W	hat Count	rv?			
ifter death with the Main of Items 23s or 28s-f or internal central formation.	2510 Hallam Co			2124			USA					
	11. Marital Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in Armed Forces? 1 ☐ Yes 2 No if Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cu I ☐ Yes 2 2 XNo	Hispanic Origin? (Sp ban, Mexican, Puarto Specify:	pecify Yes or No- p Rican, etc.)	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black					
"natural",	15. Decedent's Ed (Specify only highast gra	ucation da completed)	16a. Deced	lent's Usual Occi	upation a during most of work ed)	kina	16b. Kind of Bus	siness/Ind	ustry			
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Hygin of the Co	17. Father's Name (First, Middle, Last)	-7431				ne (First, Middle,		-	- Me			
Mental H Mental H arked off artic even	Harry Willia	ms			Lillia	n	Dunnoc	k				
and Men e marke eumatic	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street	et end Number or Ru	ral Route Numbe	r, City or Town, S	Stete, Zip	Code)			
1 and 2 Health a em 27 le rther tra	Curtis Williams	s+Latoria G	reen	2510 H	allam Co	urt Bal	timore	, M	D. 2124			
of He of He	20a. Method of Disposition		Place of Dispo	sition (Name of netory or other pi	ece)	Date	20c. Location - 0	City or To	wn, State			
Pages nent of I ant: If Its	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ings M	em. Pk	. Cem. O	3-06-99	Rand	all	stown, N			
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the death certificate be executed by the attending physician and ached for use as the burial-transit hysician/Medicat Examin	Fesuring in death) Last											
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ystclen: The List certificate he director, page	25. Was case referred to medical axaminer?				26. Place of Dea	th (Check only or	ne)					
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tal or Attending P rs after death. al Director: After t led in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, farm, streetfy)	set, factory, office				or Or Rura	Route Number,			
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	30. Name and address of person who of	·00- 0	1	Print)	Lo Baltiv	uno MD						
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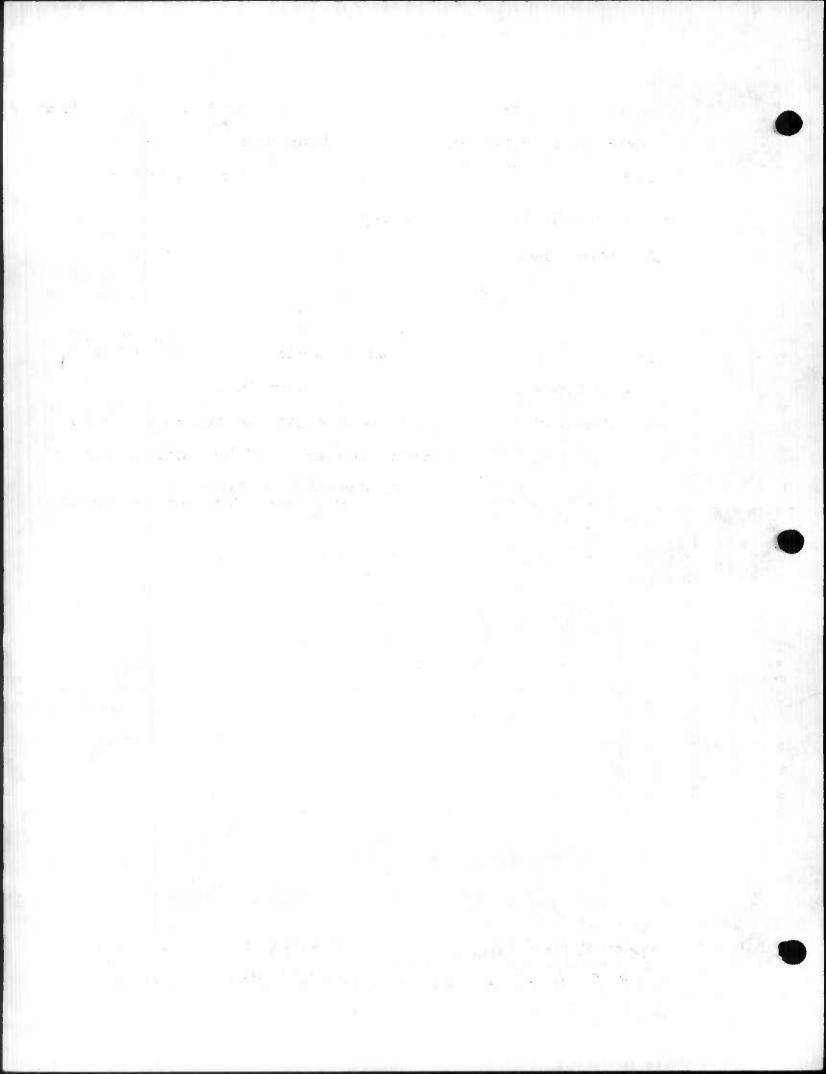


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	inyland thow		10a. State 10b. County		10c. City, Town	n or Loc					1	0d. Inside City Limits
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020	filed within 72 hours efter death with the Maryland Hygiena. ther than "natural", or items 23s or 28s-f show ont, the Medical Examines must be notified at	by	Naritel Status Never Married 2 Married Newer Married 2 Married Nidowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:		If	/as Decedent of I Yes, specify Cub ☐ Yes 2 ☐ No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		k, White,	an Indien, etc. ite
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land 2	od la b	To Be Co	17. Father's Name (First, Middle, Las Sylvester Sche	•		010	me opez		ne (First, Middle, I			mport)
Mary	d2 ther 7 is		19e. Informant's Name/Relationship Mrs. Frances E.		190.		Address (Street	t and Number or Ru	ral Route Number	,		Code) 21219
Baltimore,	ーエッち		20a. Method of Disposition 1 Burial 2 Cremation 3 Department of Control of C		20b. Plece of cemeter	Dispos y, crema	ition (Neme of atory or other pla	ice)	Date	20c. Location -	City or To	wn, State
Balti	permit. Pagas Depertment of importent: If it eny injury or once.		21. Signature of Funeral Service Lice Ohnny L.	**	Most	22. D	Neme end Addre	k Funeral	Home of	Dundal	k, I	
	Physician /Medical Examiner		23a. Part1. Exter the disease, or conshock, or heart tailure. List only Immediate Cause (Final disease or condition resulting in death)	a. Mult		rc t	TON D	e Ave. Ing., such as cardiac	or respiratory arr	Maryran est,	10 2	1222 Approximate therval Between Onset and Deeth
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o uc	Attending Physicien: or death. ector: After this cartific by the funeral director,	lon: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, De)	y. 28b. Ti	-	28c. Injui	ry at rk?	28d. Describe ho			9
Division	To the Hospital or Attending Physicien: The is within 24 hours after death. To the Funerel Director: After this cartificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined		ry - At home, fer	m, stree		Yes 2 □ No	28t. Location (St. City or Town		er or Rurai	Route Number,
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	To the company	Σ	29b. Signature and title of certifier	W	M		29c. Licens			arch		
FI			30 Name and address of person who FRY L Co	completed cause of de	eath (Item 23a) (T	Гуре, Рг	int) 18 A	J. Gree	ne S	treef	d	
	Sta	te	31. Date-filed (Mohre, Bey, Year)	32. Registre	r's Signature	/	1000	T NOT	-,09	41714	ny	



State of Maryland / Department of Health and Mental Hygiene

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caminer	ď	4e. Fecility Neme (If not insti	tution, giv	re street end num	ber)				4b. City, Town,	or Location of Dee		ty of Deeth	
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eral ctor	1	5. Sociel Security Number 215-18-7213 Usual Residence of Decader		Sex 1□M 2∏TF	7. Age (In yrs	s. last birthdey) Yrs.	If Under Months		Hours N	irs. 8. Dete of B lin. (Month, D April	ay, Year)	9. Birthp Coun 13 Mar	olece (Stete or F otry) cyland
10		10a. Stete 10b. Co			10c. C	City, Town or Lo	ocation					1	0d. Inside City
to to	5	Maryland Ca	rro1	1 Co.		Westmir	nister	r					1 X Yes 2
Director	0	10e. Street end Number					10f. Zip				10g. Citizen of	What Coun	ntry?
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by Funeral Director	1	11. Marriel Status 1 Never Married 2 3 Widowed 4 Divo	Marrled	12. Was Deced Armed For 1 Tyes If Yes, Give Year or Da	ces? 2.[X]No			dent of H	lispenic Origin? en, Mexican, Pu	(Specify Yes or N erto Rican, etc.))- 14. Ra Bie	ca - Americ eck, White, fy: Whit	etc.
	3	15. Dece	dent's Ed	ducation		16e, Deced	dent's Usua	al Occur	etion		16b. Kind of E	Business/Inc	dustry
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No." 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Year 11:03 Anna E. Smith 1999 March 01 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□M 2√2F 79 179-16-2650 Apr 15, 1919 Penna Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 3524 Roland Avenue 21211 11. Maritat Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lab_Technician Borden Ice Cream Co 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) George Barth Ethel Cammer 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Smith, Sr. (Husband) 3524 Roland Avenue, Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/5/99 Dulaney Valley Mem Gdns Timonium, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211 llan 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) . Massive Myocardial Intarction day Due to (or as a consequence of): 3 mos Coronary Arter Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

physician and the burief-transit requires that the death certificate be asscuted Hung Elizabeth Smith Division of Vital Records, P.O. Box 68760, signed by the a certificate this

Examine Physician/Medical P Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

than "natural", or liens 23s or 26s-f show the Medical Examiner must be notified at

Director

Funeral

3

Completed

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the Maryland

72 hours after

Hygiene.

pormit. Pages 1 and 2 should be lised Department of Health and Mental Hygu Important: If Isan 27 is marked other: any Injury or other traumatic event. Its

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

After thi funeral To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun.

State

Registrar

Medicai

29a. Cartifier (Check only one)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Hypertension Hyperchdesterdemia 25. Was case referred to medical examiner? Hospitel: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29b. Signature and title of certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29c. License number 29d. Date signed (Month, Day, Year)

March

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1999

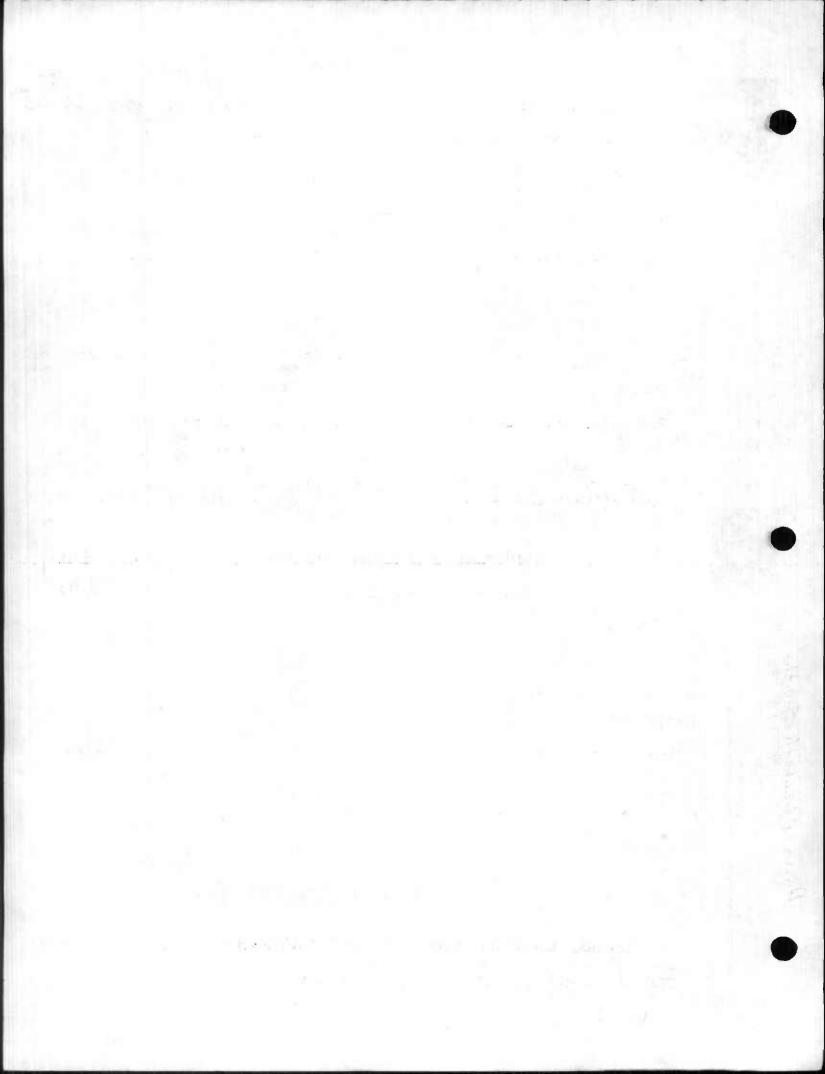
2438946

Jehad Lakkis, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tehad Lakkis 21 nion Memorial Hospital

31. Date filed (Month, Day, Year) MAR 0 5 1999 22. Registrar's Signeture

Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middla, Last) - 9g Month 3 9:11AM lber piveu 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Death Baltimore Baltimore HOSPIT2 ff Undar 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplace (Stata or Foreign Country) Months Deys Hours Min XXM 20 F 246-36-8124 31 N.C. Usual Residence of Decedent 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits XXYes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Circle South 21215 U.S.A. 2916 Edgecomb 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Navar Marriad 2 Marriad 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th grade Amoco Service na Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) David L. Spivey Ella Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Beatrice Spivey-Wife 2916 Edgecomb circle South, Balto, Md 21215 20b. Place of Disposition (Neme of cematery, crametory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 3/8/99 Timonium, 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March F/H West 23a. Part1. Enter tha disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore Md 21215 Approximete Interval Between Onset end Death 2_0=4 Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Polmonary Disease Exacerbation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initioted avents resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings availabla prior to complation of causa of deeth? 24e. Wes en autopsy performed? Fibrillation 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury st Work? 1 Naturel 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Attending Physician:

physician and the burial-transit Division of Vital Records, P.O. Box 68760, attending p for usa as signed by the certificate has b lirector, paga 2 s this funeral after death Director: 24 hours at Funeral D etaly filled

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinations to profit and page.

Physician

/Medical

Examiner

Examiner

Physician/Medical

by

Completed

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edical

29a. Certifier

(Check only one)

29b. Signature and title of certif

Certification: To the within 2

State Registrar 31. Date filed (Month, Day, Year)

MAR 5

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 32. Registrar's Signature

MD

1 (Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

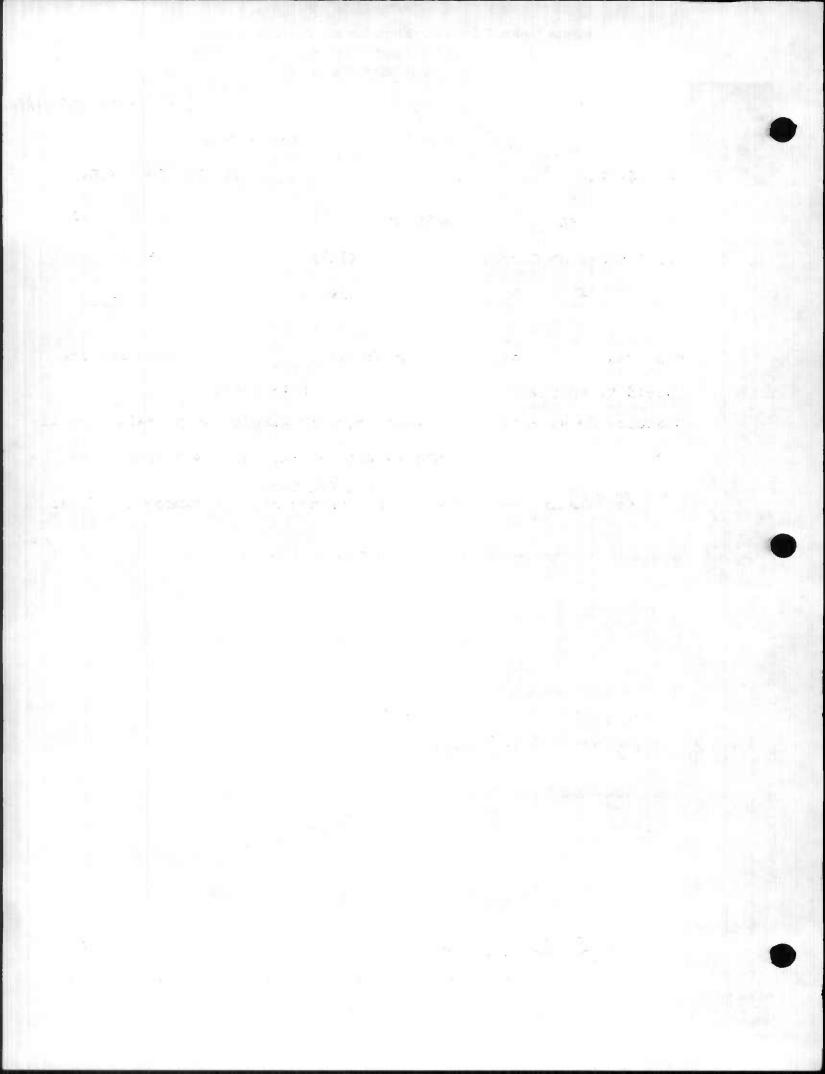
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the ceuse(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

St. Baltimore

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State of Maryland / Department of Health and Mental Hygiene

Physician	
/Medical	
Examiner	

Funeral

Director with the Maryland r 28a-f ahow I is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a permit. Peges 1 and 2 should be filed within 72 hours efter death v Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Experience.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the buriel-transit thet the deeth certificate be executed ettending pl signed by the e certificate has t irector, page 2 s Hospital or Attending Physician: After this funeral efter deat Director: To the Hospital or A within 24 hours efter To the Funeral Directompletely filled in b

Division of Vital Records, P.O. Box 68760,

Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Month Dey FEBRUARY 27, 2354 PM Robert Louis Sherman 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER Balto. City BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) August 13 1946 MD (State or Foreign MD) 5. Social Security Number 7. Age (In vrs. lest birthday) 1₽M 2□F Months Days 218-42-0446 52 Usual Residenca of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Balto, County Director Dundalk 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 2010 Frames Road 21222 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1≅ Yes 2 □ No 70-71
If Yes, Give
Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2₺ No Specify: þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondery (0-12) Potomac Abatement Contractor 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Harold Sherman Jr. Anna Ostendorf 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 2010 Frames Rd, Dundalk, MD 21222 Georgia Sherman (wife) 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery 3-9-99 Garrison Forest, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dean P Charlton 2007 Eastern Avenue, Baltimore, MD 21231
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Appro Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) a Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No Emphysema by 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause Inspection 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 28. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 □ Total Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XX es 2□ No 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury et Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Dey, Year) MARCH 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Radentz, 5. Stephen 31. Dete filed (Month, Dey, Year)
MAR 0 5 1999

State Registrar

Medical

32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 7 0 0

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		1000	C	ertificate of	Death	R	eg. No.		
B)	1. Decedent's Neme (First, Middle, L.	ast)				2. Date of Dee Month	th Day	Үөөг	3. Time of Deeth
Physician /Medical	Charles W.	Sasscer				MARCH	1, 1999	1001	1332 PM
Examiner	4e Fecility Neme (If not Institution, gi					r Location of Deeth	4c. County	of Deeth	
	GOOD SAMARITAN H	HOSPITAL			BALTIMO		N,		
Funeral Director	220-05-4236	Sex 1 M 2 □ F 7. Age (II	yrs. lest birthda Yrs	Months Devs	Hours Mi		, 1920	9. Birthp Coun Mar	lece (Stete or Foreign try) Yland
and w	Usuel Residence of Decedent 10e. Stete 10b. County	10	c. City, Town or	Location				1	0d. Inside City Limits
vith the Maryl t or 28a-1 sho be notified a	Maryland N/A			Baltimor	e				1 X Yes 2 □ No
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Within To the comple	29b. Signature end title of certifier			29c. Licen			29d. Date signe		
. 21.0	De Potta	un MI).	0.0	C.M.E.	I	MARCH 2	, 199	19
	30. Name and address of person who JOSEPH PESTANEI	completed cease of death		oe, Print) Street, E	Baltimor	e, Maryla	nd 2120	1	r per
State	31. Date filed (Month, Day, Year)	32. Registrar's		, ,					
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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			(Certificate of	Death		Reg. No.	U	1010
Physician	Decedent's Neme (First, Middle, Last					2. Dete of De Month	eeth Dey	Yeer	3. Time of Deeth
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0 (0 4 A IV 1 21215-0020 ed within 72 hours att yglene. or than "neturel", or it, the Healfeld had	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. C	Decedent's Usuel Occupation (Give kind of work done during most of wo life. DO NOT use retired)		orking	16b. Kind of Bu	usiness/Indi	ustry
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M S parting	Mrs. Eileen McGrow			Southerly (Ct. Apt.	606 Tows	son, MD.	2128	6
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To the Within 2

death

Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

State Registrar

MAR 5 1999

(Check only one)

29b. Signature and title of certifie

32 Registrar's Signatura

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

St Agnes Hospital, 900 Caton Avenue, Bultimore, MD 21229

octor

29c. License number

29d. Data signed (Month, Day, Year)

March

State of Maryland / Department of Health and Mental Hygiene Q Amended#23a pt1b perPhyG770 4/22/99 EW Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month Josephine E. Schueler February 28, 1999 5:20pm /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Charlestown Care Center Catonsville Howard 5. Sociel Security Number If Undar 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpleca (Steta or Foraign Country) **Funeral** Days 1 M 2 K F Yrs 545-26-6253 Director 95 28, 1903 California Usual Rasidance of Decedant 10a Stete 10b County 10c. City. Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore Catonsville 1 ☐ Yas 2 ☒ No Director eu 10e. Street and Number 10f. Zip Code 10g. Citizan of What Counfry? 0 713 Maiden Choice Lane items 23a 21228 USA Funeral 12. Wes Dacedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Spacify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican indian, Bleck, Whita, atc. 72 hours efter 1 Yes 2 No If Yes, Giva X Yaer or Datas: 1 Navar Married 2 Marriad Saltimore, Maryland 21215-0020 ò 1 ☐ Yas 2 No Specify: White þ 3 ☑ Widowad 4 ☐ Divorced "natural". Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) pernit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any Injury or other traumatic event. Collage (1-4or 5+) Elementery/Secondery (0-12) Photographer Denistry 17. Fether's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Malden Sumama) Be Edwin T. Ezekiel Josephine Stewart 19a. Informent's Name/Ralationship (Typa, Print) 19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Arnold T. Mench, Personal Rep 416 Carvel Beach Road, Baltimore, MD 21226 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from State 3/4/99 Mt. Olivet Cemetery Baltimore, Maryland 4 Donation Othar (Specify) 21. Signeture of Funeral Sorvice Licenses 22. Nama end Addrass of Facility Witzke Funeral Homes, 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in daath) Examiner Probably HYPEROSMOLAR COMA Examiner physician end s the buriel-transit The lew requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated avants rasulting in daeth) Lest Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Dua to (or as e consequence of): 189 es for use es Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? the 2 1 Yes 2 No 3 Probably 4 Onknown Dementio bengis be de Records, þ 24b. Wara autopsy findings availabla prior fo complation of ceusa of daath? 24a. Was an autopsy performed? Be Completed peeu page 2 s 1 Yas 20 No 1 Tyas 2 No certificate Division of Vital director, 25. Was cesa raferred to medicel axaminar? 26. Place of Deeth (Check only ona) Othar: 5 Rasidance 8 Othar (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attanding Phy within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Mangar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 Netural 2 Accidant 5 Panding invastigation 1 Yas 2 No 6 Could not be determined 3 ☐ Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the bast of my knowledge, death occurred at the time, data end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the fime, data end place, and due to the cause(s) and manner stated. Medical 29a. Certiflar 29b. Signatura end titla of certifier 29c. Licensa number 29d. Data signed (Month, Dey, Year) 30. Name and address of person who com leted cause of deeth (Item 23e) (Type, Print) Maiden Choice Ln Catarbuille Myda M Carpenter
31. Day filed (Month, Day, Year) 32 111 MD 32. Registrar's Signatura State MAR 5 Registrar

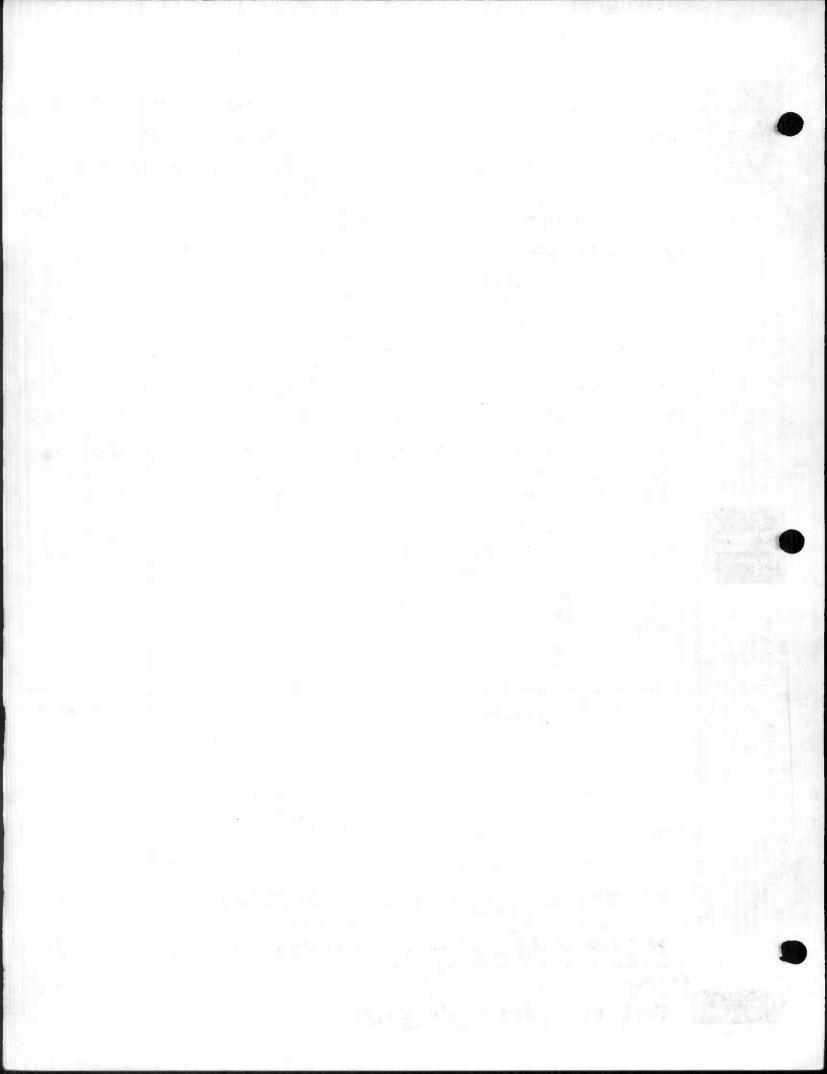
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** March 3, Day999 Donald H. Spatz 5:10pm /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Charlestown Care Center Baltimore Catonsville 5 Social Security Number If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth Month, Dev. Year, December 9, 1913 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 2 Country) D A **Funeral** 10 M 2□ F Deys Hours 202-07-7780 85 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or liems 23s or 28s-f show traumatic event, the Medical Examinal must be inclined as 1 ☐ Yes 2 ☐ No Director Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? 709 Maiden Choice Lane 21228 USA Funeral death 12. Wes Decedent Ever in U.S. Armed Forces? 1 ™ss 2 □ No If Yes, Give Yeer or Dates: W W TI 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Raca - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, the Meanes. Elementary/Secondery (0-12) College (1-4or 5+) Announcer/Writer Radio/Media Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Bela H. Spatz Laura (unknown) 19a. Informent's Neme/Reletionship (Type, Print)

John H. Gimbel (Personal Rep) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1513 Cranwell Road, Lutherville, MD 21093 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 1 Burlel 2 □ Cremetion 3 □ Removel from State 3/5/99 Laureldale Cemetery Reading, Pennsylvania 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licansee 22. Name end Address of Fecility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 Lemmer 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel EUMONIA diseese or condition resulting in deeth) WEEK Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed ed by the ettending physician end detached for use as the bunal-transit Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? n signed by the 1 Yes 2 No 3 Probably 4 Unknown EMENTIA by Completed 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? After this certificate hes 1 🗆 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Menner of Deeth Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: 6 Could not be 3 Suicide 6 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homloide To the Hospital of within 24 hours a To the Funeral D Dertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted.

| Description of the deeth occurred at the time, dete end place, and due to the cause(s) end menner steted. Medical 29a. Certifier (Check only 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M.O. 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) oth MATTHE. 7/1 MAIDEN CNOICE LANG, CATONSVILLE, MD RETT 31. Dete filed (Month, Dev. Year) 32. Registrer's Signeture State MAR 5 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene 0 070

	1. Decedent's Name (First, Middle, L						2. Dete of Dee Month	th Dey	Yeer	3. Time of Deeth
Physician /Medical	Anne E	Beatrice		Schneid	der		March		999	1:30 PM
xaminer	4e Fecility Neme (If not institution, g	ive street end number,				4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth	
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al or	378 28 1085	Sex 7. A	ge (In yrs. Ia 66	st birthday) If Un Monti	der 1 Year he Deys	Hours Min.	8. Date of Birth (Month, Dey Dec • 20	Year) 1932	9. Birthple Count Nel	ece (Stete or Foreign braska
- JC	Usual Residence of Decedent 10a. State 10b. County Maryland Monto	omery	10c. City,	Town or Location	Pot	tomac			10	0d. Inside City Limits
Funeral Director	10e. Street and Number 10249 Gainsborou			10f.	Zip Code	20854	1	Og. Citizen of V	What Count	
by	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Decedent Armed Forces	?			Hispenic Origin? (Sp an, Mexican, Puerto Specify:	gin? (Specify Yes or No- h, Puerto Rican, etc.) 14. Race Bleci Specify.			an Indien, etc. hite
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To Be	17. Fether's Name (First, Middle, La: Bion		ffman			18. Mother's Nam Beatric		Maiden Sumen		mith
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	John D. Schniede	r / Husbar	d	10249	Gain	sborough	Rd., Pot	comac, N	1D :	20854
To	20a. Method of Disposition 1 Buriel 2 A Cremation 3 4 Donetion 5 Other (Spec		cer	ca of Disposition (metery, cremetory on en Mount	or other ple	atory 3/	Dete 4/99	20c. Location - Baltir		
cian iner	21. Signature of Funeral Sarvine Lic	2		CAFA 8717	Step Green	hen D. Lo n Pasture	hrmann F	A. Baltimon	re, M	D 21286
	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions,	θ. Metast	Due to (or	Breast Ca as a consequence as e consequence	of):				2	? Years
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sicie	Pert II. Other significant conditions	contributing to death I	out not result	ting In the underlying	ng cause gi	ven in Pert I.	23b. Did to	obacco use co	ntribute to	the cause of death
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Completed				115			24e. Wes e perfor	en autopsy med?	cor	ere eutopsy findings eilable prior to mpletion of cause deeth?
NO.							1 □ Y	es 2XXVo	1	Yes 2□ No
Be Com	25. Was case referred to medical examiner?					26. Plece of Dea	ith (Check only or	ne)		
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Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Placa of In	jury - At hon tc. (Specify)	ne, ferm, street, fed			28f. Location (S City or Tow	Street end Numb m, State)	per or Rure	l Route Number,
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Daath 3. Tima of Death 6.25 AM LERCY SHAVER TEBRUMLY 2617 1999 4a. Facility Name (If not Institution, giva streat end number) 4b. City, Town, or Location of Daath 4c. County of Deeth Baltimore City Good Samaritan Hospital Baltimore City If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthday) 8. Deta of Birth (Month, Day, Year) Birthplace (Steta or Foraign Country) 1, M 2□ F Days Yrs. 215-32-6002 Nov. 6, 1933 Maryland Usual Rasidanca of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore City Maryland Baltimore City tXXYas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 21214 6219 Pioneer Drive USA 12. Wes Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 11. Marital Status 1 Navar Married & Married t DYYas 2 No KYas, Giva Korean Yaar or Datas: 1 ☐ Yas 2 No Specify: Specify: White 3 ☐ Widowad 4 ☐ Divorcad Conflict

16a. Decedent's Usual Occupation
(Give kind of work dona during most of working life. DO NOT use ratired)

State of the confliction of t 15. Dacedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collage (1-4or 5+) Insurance Com. Staff State of Maryland 12 yrs. 3 yrs. 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Sumama) Leech M. Shaver Jennie A. Moxley 19a. Informent's Neme/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Numbar, City or Town, Stata, Zip Code) Barbara Shaver-Phillips (Wife) 6219 Pioneer Drive Baltimore, Maryland 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cremetion 3 Ramoval from Stata 4 Donation 5 Other (Specify) Dulaney Valley Mem. Gdns. 3-1-1999 Baltimore, Maryland 21. Signature di Funeral Service License 22. Name and Address of Facility
Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 anti-chier the discrete, or complications that caused the daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, lock, or heart failure. List only one ceusa on each line. Approximata Interval Batw PANCREATIC Immediate Ceusa (Final CARCINOMA IYETTR diseasa or condition rasulting in death) Sequantially list conditions, if eny, laading to Immediata causa. Entar Underlying Cause (Disaasa or Injury that initiated avants resulting in daath) Last Due to (or as a consequence of): Due to (or as a consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ¥ Yes 2 No 3 Probably 4 Unknown 24b. Wara eutopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was case rafarrad to medical 26. Place of Death (Check only one) axaminar? Othar: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Spacify) 1 ☑Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

itam 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after teppartmant of Health and Mental Hygiena. Important: If Itam 27 is marked other than "natural", or ther any Injury or other traumatic event, the Medical Exercises.

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

the Maryland

with

death

that the death certificate be executed as tha burial-transil and nding physician atten P been signed by should be datac has paga 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I in by t

Examiner Physician/Medical by Completed Be P Certification:

27. Mannar of Death

1 Netural

2 Accident

3 Suicida

29a. Certifier (Check only one)

4 Homleida

5 Pending invastigation

6 Could not be determined

edical

State Registrar

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signature and title of certifier

28e. Data of Injury (Month, Day Year)

29c. Licensa number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Data signed (Month, Day, Year)

Location (Street end Number or Rural Routa Number, City or Town, Stete)

28d. Dascribe how Injury occurred

MEDICIN DOCTOR D0025511

28b. Tima of

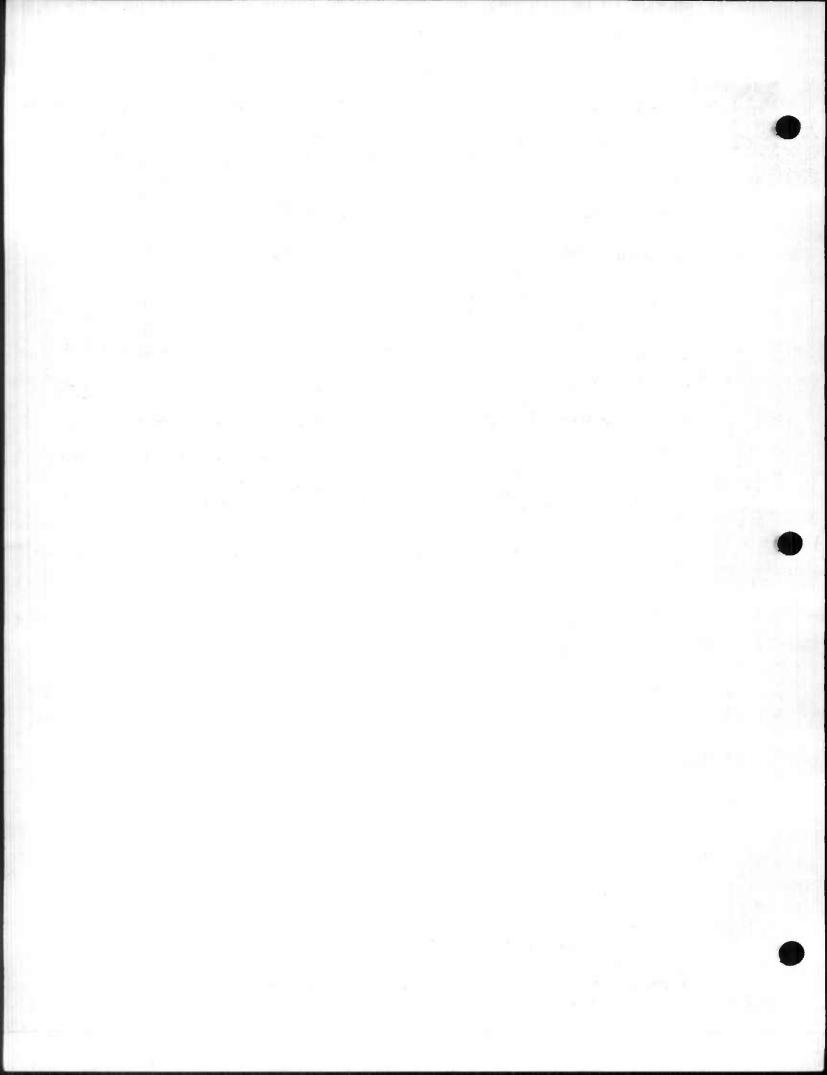
28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

FORMHAY 26 TH 1999

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

KWASHLE ATTIOGRE GOST SAMMITTAN HOSPITAL OF MARYLAND INC FRANCIS

31. Data filed (Month, Dan AR) 5 1999 Registrar Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dey Albert Bartholenew Schott February 28, 1999 12:10p.m. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Chesapeake Health Services Amold If Under 24 Hrs. Anne Arundel Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, June 23, 5. Social Security Number 7. Age (In yrs. lest birthdey) 1QM 20F Months Deys Hours 217-01-3555 82 Yrs. Overlea, Maryland Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Baltimore Baltimore County 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 6909 Beech Avenue 21206 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status Bleck, White, etc. 1 ☐ Yes 2 € No If Yes, Give 1 Never Married 2 Married 1□ Yes 2□No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Laborer Bethlehem Steel 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Charles J. Schott Emma K. Kahl 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Louise C. Gott (Daughter) 4005 Alberta Avenue Pasadena, Maryland 21122 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 XXBuriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cem. March 4, 1999 Baltimore, Maryland 22. Neme and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home, Inc. 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Ceuse (Finel diseese or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or es a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 CH 1 Yes 1 Yes 2 No 25. Wes case referred to medica 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending 2 No investigation 2 Accident

Examiner The lew requires that the death certificate be executed physician and the buriel-tran Division of Vital Records, P.O. Box 68760, Physician/Medical 98 980 been signed by the should be deteched þ Completed page 2 certificate funeral director. Be P this Certification: Affer

Physician /Medicai

Examiner

Physician

Examiner

Funeral

Director

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with the Merylenc

death

permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or item any injury or other treument.

altimore, Maryland 21215-0020

/Medical

Directo

Funeral

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Completed

Hospital or Attending Physician: ofter deeth. Director: Aft 44 hours e

29e. Certifier

3 Suicide

4 Homicide

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated.

29b. Signeture end title of cartifier

6 Could not be determined

29c. License number

29d. Dete signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stare)

My 30. Neme and eddress of per ha completed cause death (Item 23e) (Type, Print)

Garbany Elliott 7845 Oakwire MO

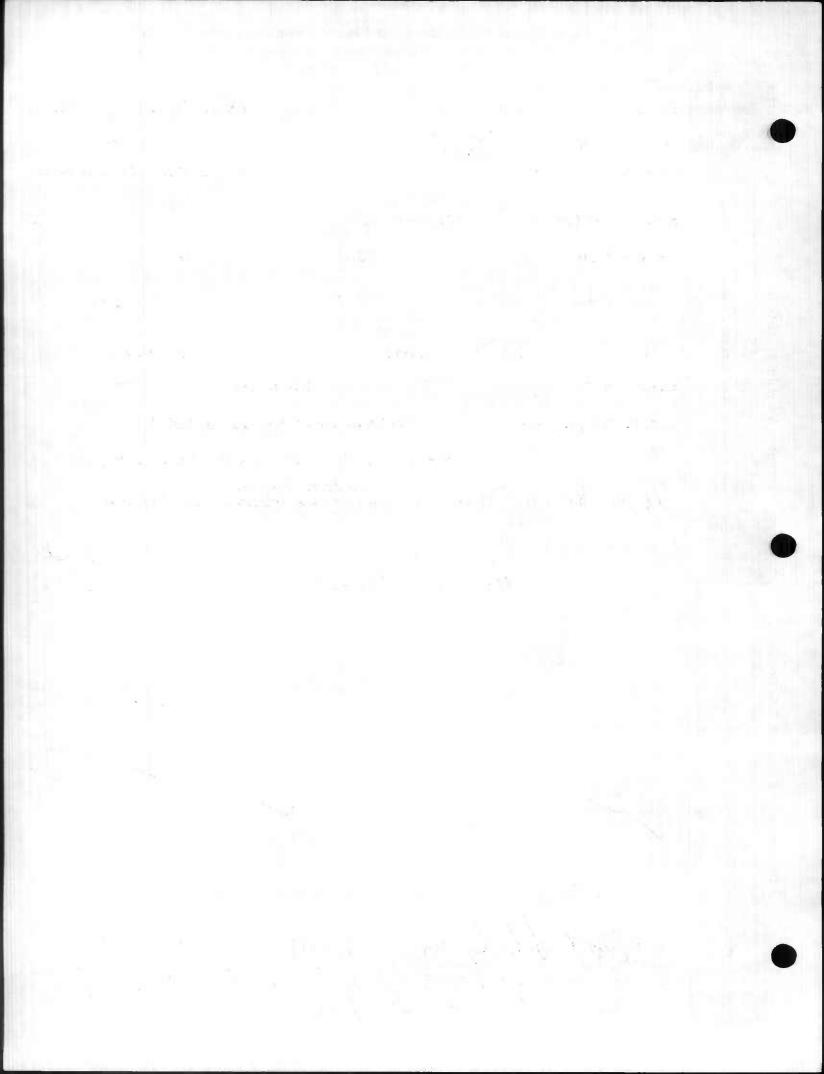
32. Redistrar's Signature

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

State Registrar

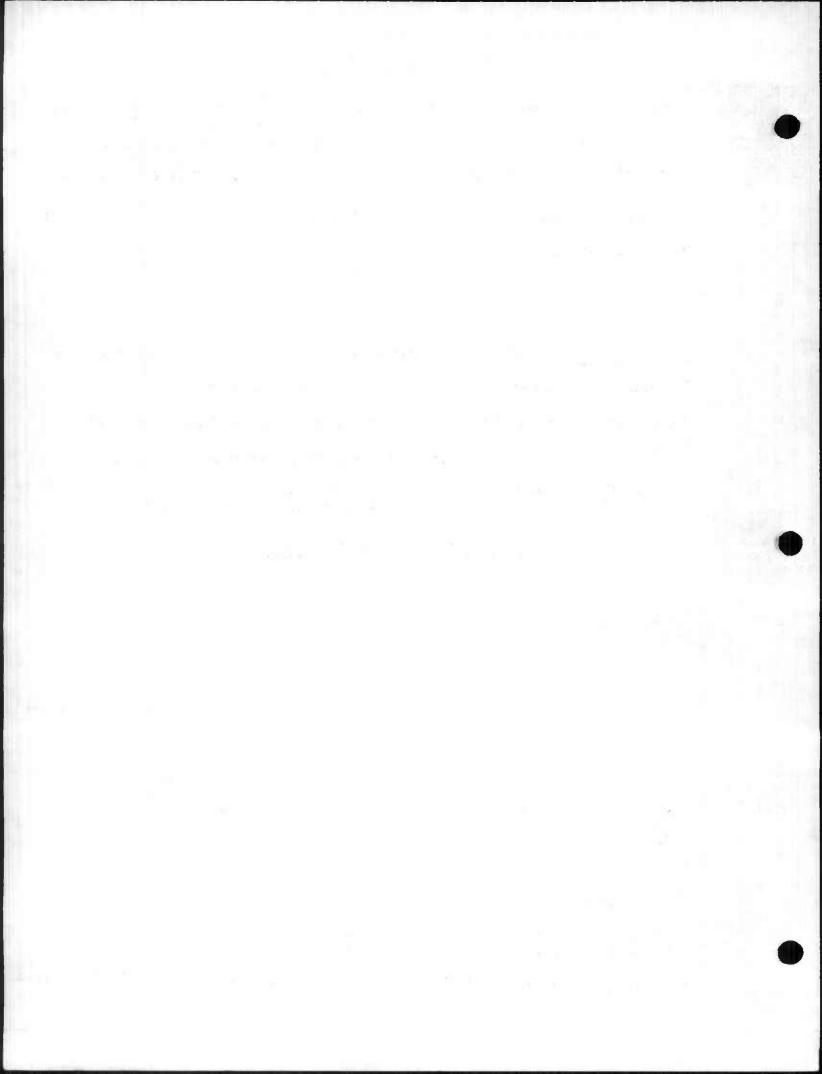
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State of Maryland / Department of Health and Mental Hygiene

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23a or 2	al Dire	9719 Philadelph	nia Rd.				10f. Zip 0	Code	21237		10g.	Citizen of V	Whal Count	fry?	
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Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9

				State of Maryla		rtificate of			Reg. No.	07018
	Physic		1. Decedent's Name (First, Middla, La. CEC/L	THOM	PSON	/		2. Date of Dec Month 0 2	Day	Year 99
	/Medi Examii		4a. Facility Name (If not institution, giv	street and number)			4b. City, Town, or	Location of Death		
7	Exami		University Hos	g			Baltimo	ore	NA	
	Funeral		5. Social Security Number 6. S	ex 7. Aga (In y)	rs. last birthday)	If Under 1 Yaar			h Year	Birthplaca (State or Foreign Country)
	Director		132-44-6811	XM 2□F 47	Yrs.	Months Days	Hours Min	06 2		S.C.
Н	p .		Usual Residence of Decedent							
	show	20	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	deeth with the Meryland ms 23s or 28s-f show r mat be notified at	Funeral Director	MD NA	В	altimo	re				1 XYes 2 No
	中 50 年	Sire	10e. Sfreef and Number			10f. Zip Code			10g. Citizan of V	What Country?
	th w	<u>a</u>	5328 Nelson Av	7e		212	15		U.S.	Α.
	dee The	ner	11. Marital Status	12. Was Decedant Ever in Armed Forcas?	U,S. 13. \	Was Decedant of H	lispanic Origin? (S	Specify Yes or No-	- 14. Rac	e - American Indian,
21215-0020	buid be filed within 72 hours efter deeth with the Merylar Mentel Hyglene. arked other than "natural", or items 23s or 28s-f show after other than "natural", or items 23s or 28s-f show after other than the routing as	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Giva Year or Datas:		1 ☐ Yas 2X No		to Fican, etc.,	Specify	ck, White, etc.
Ö	2 hou	P	15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occur	pation		16b. Kind of Bu	usiness/industry
215	nin 7	Completed	(Specify only highest gra		(Giva life. L	kind of work done DO NOT use retire	during most of wo d)	orking		,
21	d with	Eo	10th grade	College (1-4or 5+)	Main	tance			Vario	us Jobs
P	office Hyg	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumam	10)
<u>a</u>	should be filed within and Mentel Hyglene. marked other than matic event, the Mentel Men	TOE	Walter Thompson	1			Mary S	Simms		
Maryland	ges 1 and 2 should it of Health and Meni if item 27 is marked or other traumatic or		19a. fnformant's Name/Relationship (ype, Print)	19b. Mailin	ng Address (Street	and Number or R	ural Route Numbe	er, City or Town,	State, Zip Code)
	1 and 2 Health em 27 is		Mary Lindsey-Mo	other	5328	Nelson	Ave,	Baltimo	re Md	21215
ore	of He item		20a. Method of Disposition	20b.	Placa of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location -	City or Town, Stata
E	Pege int: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 2)	nemoval from State		Mem. F		3/6/99	Baltim	ore, Md
Baltimore,	permit. Peges 1 and Department of Health important: if item 27 any injury or other tr once.		21. Signature of Funeral Service Lican		22	. Name and Addre	ss of Facility			
m	Departiment important		1400	42.	M	larch F/	H West	o Dolt	imoro	Md 21215
	_		23a. Part1. Enter the disease, or companies shock, or heart fallure. List only	olications that caused tha de						Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	4	ATION	-	NEUME			Interval Between Onset and Death
		- a	Inchigateor,	Due to	(or as a conseq	uence of):				
	oned J snsit	Examiner		b		1				
o,	tificete be executed g physician end es the bunel-transit	Exa	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated avents	DO FO	(or as a conseq	uerice or):				
68760,	yslciu	edical	Cause (Disease or Injury that initiated avents resulting in death) Last	C. Due to	(or as a consequ	uance of):				
	ng ph es ti	-	resolving in death) Last							i
Box	eath cer ettendin for use	2		d						
	the ette	sicia	Part II. Other significant conditions of	onfributing to death but not re	esulting in the ur	nderlying cause giv	ren in Part I.	23b. Dld t	obacco use cor	ntribute to the cause of death?
P.0	het the de ad by the deteched	Physician/N	RECURRENT	_				10	Yes 2 No	3 Probably 4 Unknown
	gned ge de	by F								
of Vital Records,	The lew requires that the death cer ale has been signed by the ettendin page 2 should be deteched for use	eted	DIABETES	MELLITA	25			24a. Was perfo	an autopsy med?	24b. Were autopsy findings available prior to completion of causa
i Re	The lew ate hes page 2	Completed	SUBSTANCE	ABU	SE			101	res 2 No	of death?
ita	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?				28. Place of De	ath (Check only o	ne)	
5	G is X	2	1 Yas 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth	er: 4 ☐ Nursing I	Home 5 ☐ Resid	lence 6 Oth	er (Specify)
n	ng Ph fter th ineral		27. Manner of Death 1 Nafural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor	y at k?	28d. Describe h	now injury occurr	red
Division	Attending ir death. actor: After by the fune	Certification:	2 ☐ Accident investigation				Yes 2 □ No			
Ž	her different frect	E	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eef, factory, offica		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural Route Number,
	ral D									
	To the Hospital or Attending Phythin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	(Uneck only 2 Medical Exam	raician: To the best of my kr iner: On tha basis of examin	nowledge, death nation and/or inv	occurred at the tir	me, date and place pinion, death occ	e, and due to the durred at tha time.	cause(s) and me	nner as stated. and dua to the cause(s)
	the I	Med	one)	and manner stated.						
	5 4 ½ 5 g		29b. Signature and fitla of certifier	110 - 0- 4		29c. Licens				d (Month, Day, Year)
	V	1	Suit Ju			0 2	-6375		3/4/	77
	WZ		30. Nama and address of person who of SUR JIT JUL	completed cause of death (Item 23a) (Type, Print)				7. BA	ALTIMO	RE MD 2120/
	Sta	te	31. Data filad (Month, Day, Year)	32. Registrar's Sign						

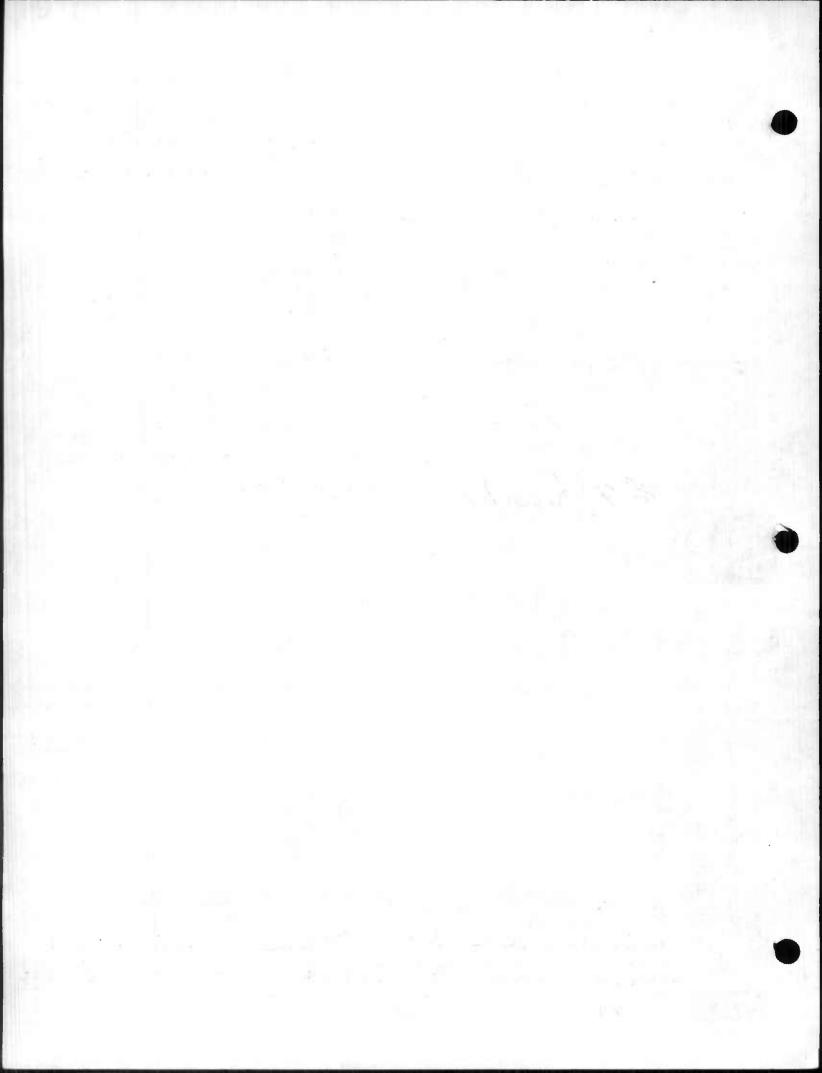
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Yaar Peggy M. Tyler 23,1999 Feb. 6:17PM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner White Marsh
If Under 1 Year | If Under 24 Hrs. | 8. 5816 Affeld Avenue Baltimore 5. Social Sacurity Number 6 Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 X F Months Days Hours Min Yrs. Director 60 March 16,1938 Baltimore, Maryland 213-36-2706 the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 Yas 2 No Director Maryland Baltimore White Marsh 10e. Streat and Number 10f. Zip Code 10g. Citizan of What Country? ò Herns 23a Funerai 5816 Affeld Avenue 21162 U.S.A. 12. Was Dacedant Evar in U.S. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status Armed Forcas?

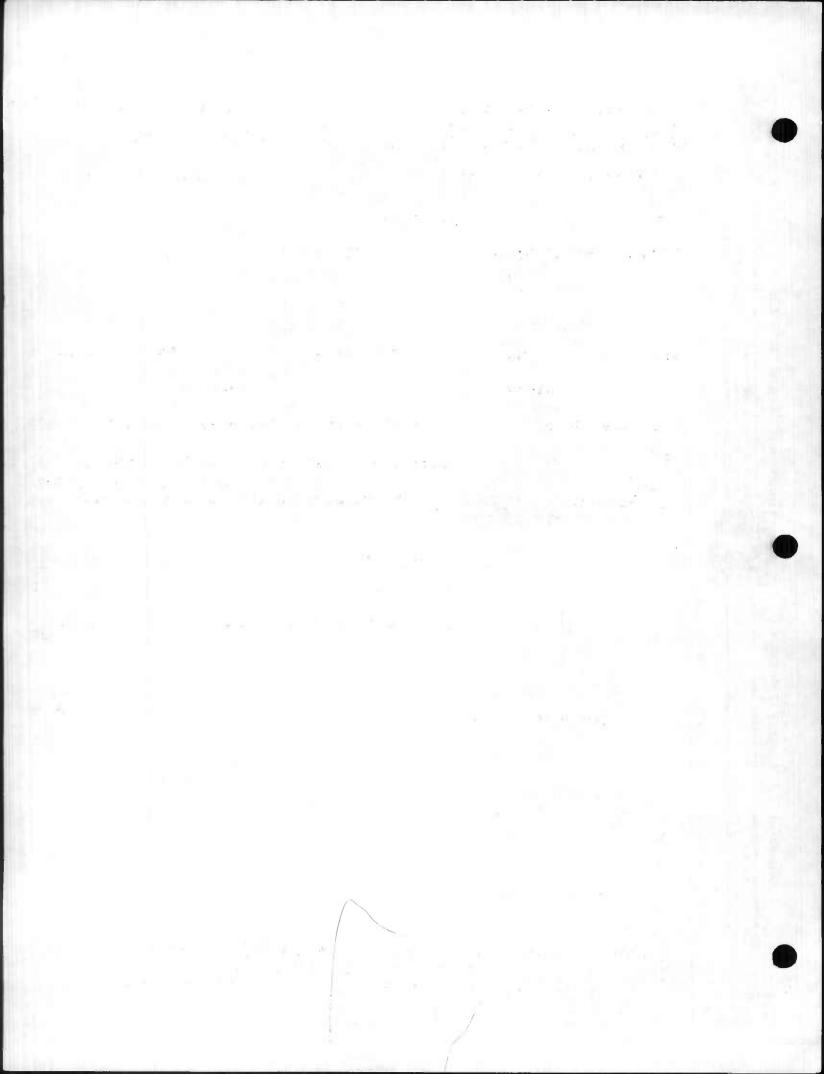
1 Yas 2 No
If Yas, Giva
Yaar or Datas: 72 hours efter 1 Navar Married 2 Marriad ò Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacadant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 next of Health and Mental Hygiene. Elemantary/Secondary (0-12) Collaga (1-4or 5+) Childcare Industry 7 vrs. Day Care Provider 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Gordon Monroe Mary Jane Stinchcomb 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) Mrs. Vickie L. Fleischmann (Niece) 17 Holcomb Crt. Baltimore, Md. 21220 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 1 Durial 2 Cramation 3 Ramoval from Stata Department of important: If any injury or stick. 4 □ Donation 5 □ Othar (Spacify) BelAir Memorial Gardens 2/27/99 BelAir, Md. 21014 21. Signature of Funeral Service Ligense 22. Nama and Addrass of Facility E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ician and bunal-trans Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or as a consequence of): P.O. Box 68760, physician s the bunal Physician/Medicai Due to (or as a consequence of): USB 88 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No signed b Records, þ cete hes been sig , page 2 should b Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? 2 14 No certificate 1 □ Yas 2 □ No Division of Vital or Attending Physician: Be 25. Was casa rafarred to medical 26. Placa of Daath (Chack only ona) axaminar? Othar: 4 Nursing Homa Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 5 Rasidanca 6 Othar (Spacify) this funerai 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? Affer 5 Panding Invastigation 1 Natural death. 1 □ Yas 2 □ No ours after death leral Director: A filled in by the fi 2 Accidant 3 Sulcida 6 Could not be datamined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital o within 24 hours af To the Funeral Di completely filled is Medicai 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signatura and titla of certifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number 26. J. Crossan 7632 tonova 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

T.C.ROSSAN OHONOVAN M.D. 2.11 MD 2112 DUNDALK AVIST BALTO 21222 31. Data filad (Month, Day, Year) 32. Registrar's Signature. State MAR 5 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** WORMLEY 4-28 pm Daniel 1999 March /Medical Town, or Location of Death 4c. County of Death Name (If not instituțion, giva street and number) 4b. City. Examiner S. Social Security Number ealth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. fast birt **Funeral** 1 €M 2 □ F Days Min 228-07-7165 83 Director VA 11-24-15 Usual Residence of Decedent 10a. Slata 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5700 Northwood Drive 21212 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. e filed within 72 hours after at Hygiene. other than "naturel", or ite ty∏Yas 2 No If Yes, Giva Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Lumber Jack Robinson's Lumber 9th Grade 18. Mother's Name (First, Middle, Maidan Sumama) 17. Fathar's Name (First, Middle, Last) 12 should be finance and Mental H IInknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st Department of Health and Important: If Item 27 is m any injury or other traum 5700 Northwood Drive Baltimore, MD. 21212 Beatrice Jones 20b. Place of Disposition (Nama of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State MD 1 Burial 2 Cremation 3 Ramoval from Stata
4 Donation 5 Other (Specify) Garrison Forest VA Cem. 03-09-99 Owings Mills 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Servica Licanses less WM.C.March FH 1101 E. North Avenue 23a. Part 1. Enter the disease, or conshock, or haart tailura. List only blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximata Intarval Batwaen Onset and Death **Physician** /Medical tmmediate Cause (Final disaase or condition resulting in death) Examiner Due to (or as a consequanca ot): Examiner Preumonia attanding physician and for use as the burial-trensit Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disaase or Injury that Initiated events rasulting in daath) Last Dua to (or as a consequence of): Myo cardial
Due to (or as a consequence ot): Box 68760, Physician/Medical Part tt. Other significant conditions contributing to death but not resulting in the undariying cause given in Part I. ed by the a 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Prostate Cancer by 24b. Wara autopsy tindings available prior to completion of causa of daath? 24a. Was an autopsy Completed 1 Yes 2 No 1 Yes 2 No Division of Vital Attending Physician: 25. Was case reterred to medical examiner? 26. Place of Death (Check only ona) Be 1 Yes 25 No Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 28d. Dascribe how injury occurred 28c. tnjury at Work? 28a. Date of tnjury (Month, Day Year) After 1 Natural 2 Accident 5 Panding deeth. 1 ☐ Yes 2 ☐ No invastigation or Attended ofter deet Director: 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Spacify) 4 Homicida 24 hours 15 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number Usley, Aban MD PHO P11783 March 2, 199
30. Name and address of person who completed clause of deeth (Item 23a) (Type, Print) Dale G. Schaar, M.D.
University of Maryland Wedical System Baltimore Maryland 8 4114 Marylan & Me 92. Registrar's Signatura 31. Date tilad (Month, Day, Year) State MAR 0 5 1999 Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. ITEMS: #23 PART I, 27 PER MEO G769 3-10-99 WR. Certificate of Death

,	3.0	a	0	7	n	2
	Reg. No.	3	U	I	U	6-

	1. Decedent's Name (First, Middle, Last)
Physician /Medical	JAMES Josep
Examiner	4a Facility Name (If not institution, give s

JAMES Joseph WARNER

6. Sex

1 M 2 F

Month Day

2. Date of Death

8. Date of Birth (Month, Day, Year)

February 16,1951

3. Time of Death Year 1999 6:20

Birthplaca (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

New Jersey

PARKWYRTH 5. Social Security Number

4a Facility Name (If not institution, give street and number) AVE

7. Aga (In yrs. last birthday)

48

Yrs.

BALTIMORE

10c. City, Town or Location

4b. City, Town, or Location of Death BALTIMORE

If Under 24 Hrs. Hours Min.

Specify:

26 4c. County of Death

Funeral Director

"naturel", or items 23a or 28a-f show edical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mental Hygiena.
ntt. If Item 27 Is marked other than "naturel", or item
ury or other traumatic event, the Medical Engine

permit. Pages 1 and Department of Health Important: If them 27 eny Injury or other tr page.

Physician /Medical

Examiner

physician and the burial-transit

attending pi

signed by the a

should I

s cartificate has b

director

5 Direc

5

this funeral

After

death.

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medicai

þ

Completed

Be

Certification: To

Medicai

Baltimore, Maryland 21215-0020

Directo

Funeral

þ

Completed

Be

the Maryland

with

death v

147-44-0996 10a. State

11. Marital Status

Usual Residence of Decedent 10b. County MARYLAND BALTIMORE CITY 10e. Street and Number 638 PARKWYRTH

HUENUE 12. Was Decedent Ever in U,S. Armed Forcas?

1 ☐ Yes 2 No If Yes, Give Year or Datas:

College (1-4or 5+)

10f. Zip Code 2/2/8 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.)

1 ☐ Yes 2 No

If Under 1 Year

Days

Months

10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc.

Specify: Write

15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) 12

1 ☐ Naver Married 2 ☐ Married

3 Widowed 4 Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER

16b. Kind of Business/Industry Construction

17. Father's Name (First, Middle, Last)

WARNER JR.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

18. Mother's Name (First, Middle, Maiden Surname) JANEL MARY NORUEL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

ERNEST HENRY 19a. Informant's Name/Relationship (Type, Print)

DIANNE Wheaton, Sister 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

638 PARKWYRTH Avenue BALHMORE, MD 21218 Date 20c. Location · City or Town, State mARCH

4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Lie

METER GREMATORY

2,1999 CATORSUILLE, MARYLAND D 22. Name and Addrass of Facility AMBROSE FUNERAL HOME, INC

23a. Part 1. Enter the disease, or complete on that cause shock, or heart failure. List only one cause of tach

1 ☐ Burial 2 ☑ Cremation 3 ☐ Ramoval from State

death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

SEIZURE DISORDER Due to (or as a consequenca of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Dua to (or as a consequence of):

Due to (or as a consequance of):

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Anknown

24a. Was an autopsy performed? Pown BL

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 2 No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1⊠Yes 2□ No 27. Manner of Death

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accidant 3 Suicide

4 Thomicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifie

29c. Licansa number

29d. Date signed (Month, Day, Year)

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O.C.M.E

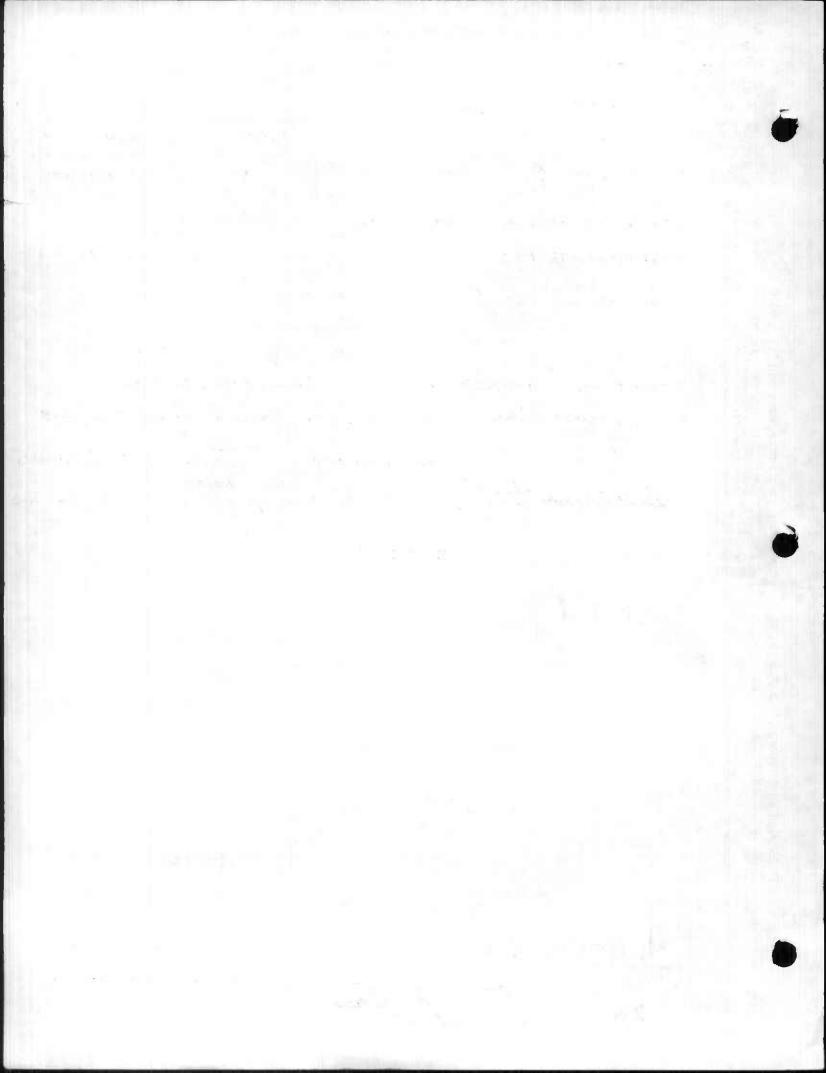
FEBRUARY 26, 1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

HOMADONO 31. Date filed (Month, Day, Year) 1999

A. 160152 Mm 2. Registrar's Signature 111 Penn Street, Baltimore, Maryland 21201

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death MARY WATTS 1700 Hrs 1999 MARCH 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12 ANDALL STOWN BALTIMORE NORTHWEST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sex 1 □ M 2 🖾 F 86 28, 1912 214-66-6214 Maryland Usual Residence of Decedent 10d Inside City Limits 10a State 10h County 10c. City. Town or Location 1 ☐ Yas 2 No Maryland Baltimore Pikesville 10e, Street end Number 10f. Zip Code 10g. Citizen of What Country? 301 Church Lane 21208 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 11. Maritai Status Btack, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewife Own Home 12 Years 18. Mother's Neme (First, Middle, Meiden Surnema) 17. Fathar's Nama (First, Middle, Last) John Kuchar Kristina Bryl 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Coda) Mrs. Sharon Turrall 1309 Saddleback Road Pikesville, MD 21208 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Druid Ridge Cemetery 3/6/99 Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. Lens 8728 Liberty Road Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or raspiratory arrest, shock, or heart feiture. List only one cause on each line. SEPSIS Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown COLON CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 PNo 25. Was cese referred to medicet 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Department 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation

Physiclan /Medical Examiner

Examiner

Physician/Medicai

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Completed

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Certification:

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Naturel Nature

2 Accident

3 Suicide

29a. Certifier

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(Check only one)

Physician

/Medical

Examiner

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Funerai

py

Completed

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after t. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or item any Injury or other traumatic event

Baltimore, Maryland 21215-0020

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death

physician and s the burial-transit à signed I certificate has t lirector, page 2 s this

Division of Vital funeral After I or Attending after death. I Director: Aft To the Hospital o within 24 hours aft To the Funeral Di

State Registrar 29b. Signature and title of certifier

6 Coutd not be determined

29c. License number 37333

10 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

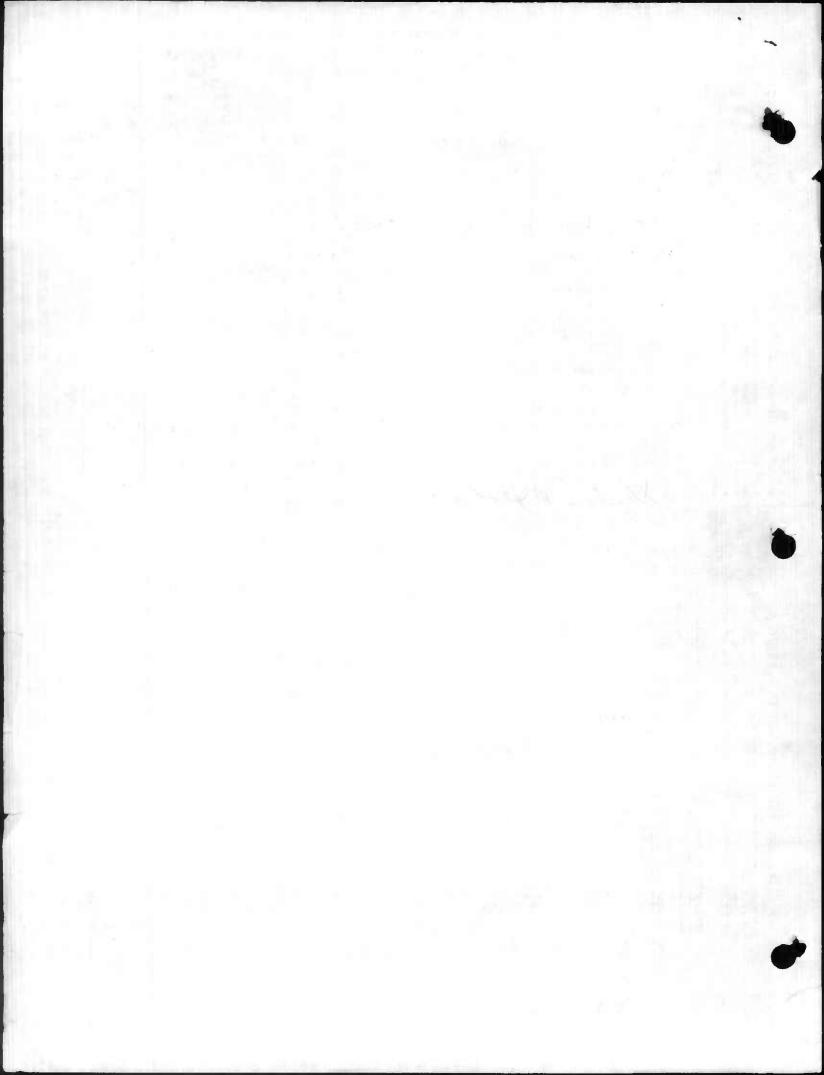
1 Yes 2 No

MARCH 3, 1999

· RAVIMO, NHC, BALTO. MD 21133

31. Dete filed (Month, Pay, Year) 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Month

3. Time of Deeth

Physician /Medical **Funeral**

March 1999 8:05PM Leona I. Young 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Medical Center Baltimore Towson 7. Age (In yrs. last birthday) 68 Yrs. If Under 24 Hrs 5. Sociel Security Number 483-32-3375 If Under 1 Year 8. Dete of Birth May Ch 12" 1930 Birthplace (State or Foreign Country)
 TOWA Hours Months Director Usual Residence of Decedant the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show mant be notified at MD. Baltimore Towson 1 ☐ Yes 2 X No Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? "natural", or items 23a or 8209 Yarborough Rd. 21204 USA death Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Americen Indian, Black, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? filed within 72 hours after Hygiena. Wher than "natural", or Ne 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) +1 Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygient Important: If Nem 27 Is marked other tha enty Injury or other traumatic acceptants. Personnel Specialist Social Security Adm. 17. Fathar's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Surname) Be V. Levasseur Leo Josephine Minear 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Frederick Young/Husband 8209 Yarborough Rd. Towson, MD. 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 3-4-99 Hilltop Service Co. Towson, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
RUCK TOWSON Funeral Home,
1050 York Rd. Towson, MD. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or haart tailura. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consaquence of) Examiner physicien end s the bunal-transit Sequentielly list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as e consequence of). Box 68760, Physician/Medical Due to (or as a consequence of) 88 the attending USB Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contributs to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ been si 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate director. Be 25. Was case rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1FTYes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t 5 Pending investigation or Attending 1 PNatural after deeth.

I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

2 Description Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

2 Description Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and file of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Neme and addrass of person who completed cause of death (Item 23a) (Type, Print) Charles

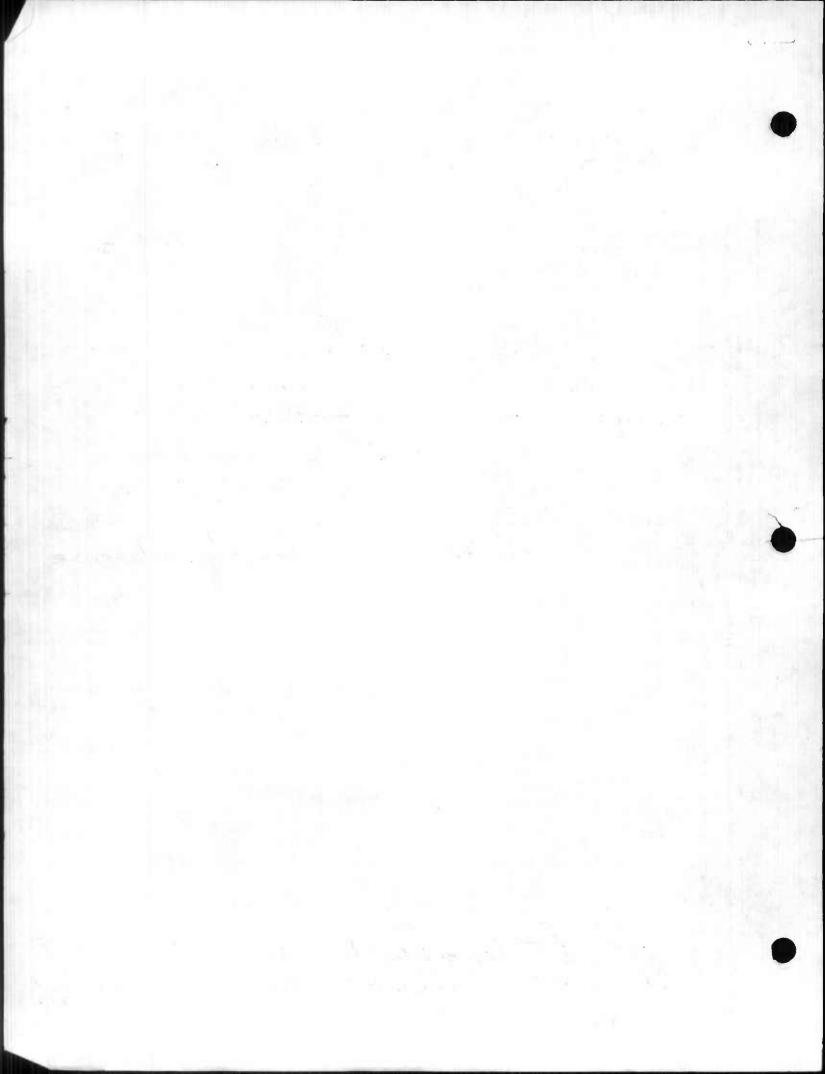
DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year)

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32. Registrar's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

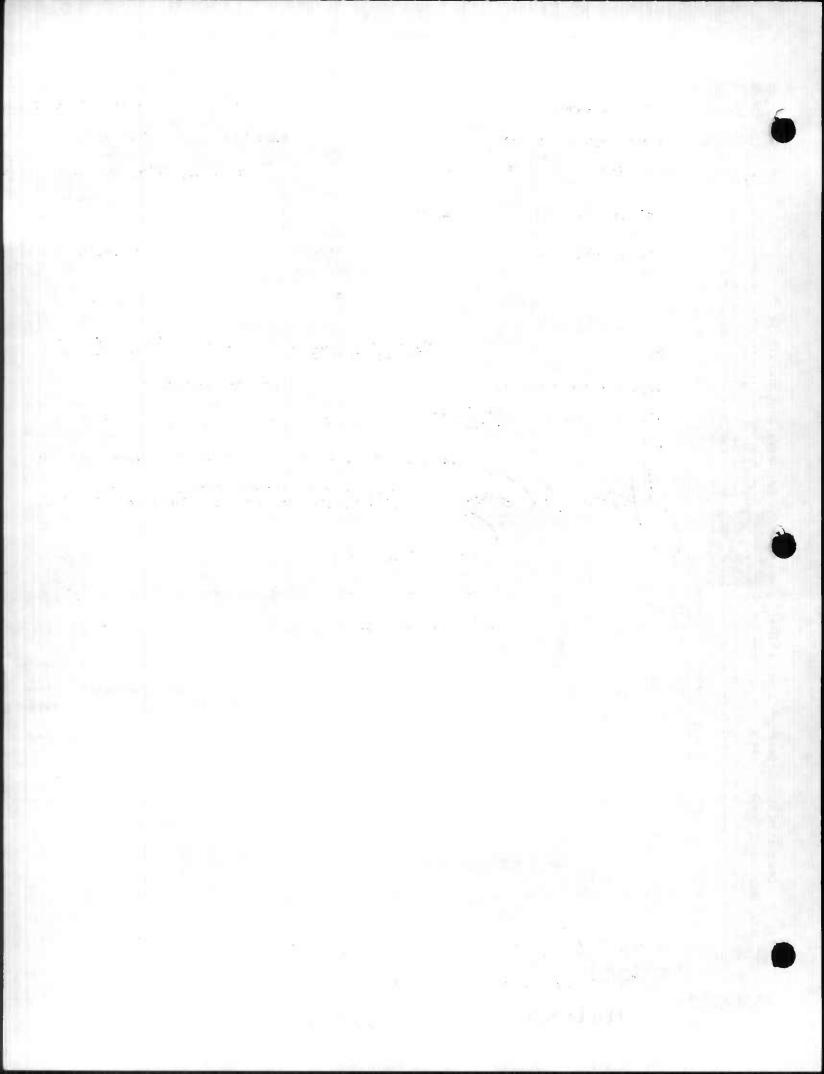
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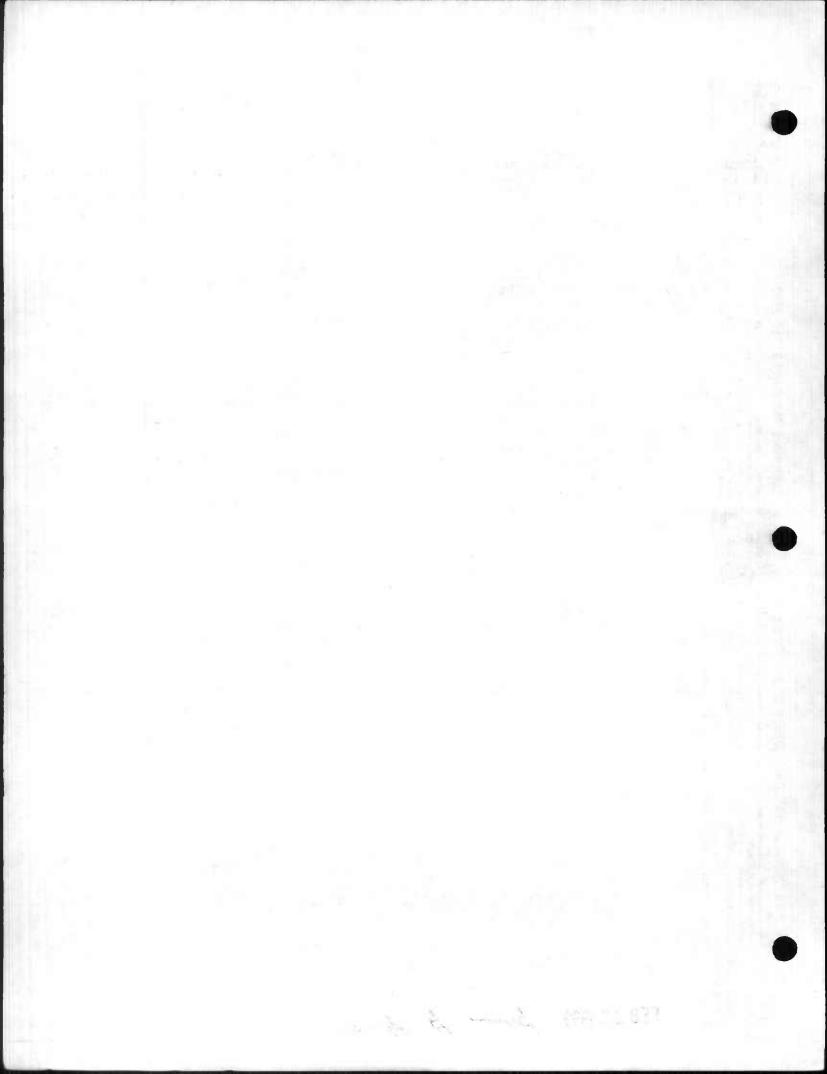
	1. Decedent's Name (First	st, Middle Les	()		00/1	ificate of	Dodin	2. Date of De	Reg. No. eth		3. Time of Death
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	5. Social Security Numbe 216-07-1626	er 6. Se		(In yrs. li	ast birthday) Yrs.	if Under 1 Yea Months Deys	r If Under 24 Hr		th y, Year) 7, 1918	9. Birthp Coun Mar	lace (State or Fore try) yland
	Usual Residence of Dece										
tor	Maryland 10b.	Carrol	1		odbine	ation				1	0d. Inside City Lim 1 ☐ Yes 2 🖾
Director	10e. Street and Number					10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?
	7212 Wood	ibine Ro	oad			21	797		United	Stat	tes
by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 I		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:			es Decedent of Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Bled	e - Americ ck, White, White	etc.
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900	17. Father's Name (First,	, Middle, Last)					18. Mother's No	ame (First, Middle	Maiden Sumem	10)	
9	Hugh Alex						Mary	yanne Don	naldson		
	19a. Informent's Name/F	Reletionship (T)	ype, Print) Daugh	ter-	19b. Mailing	Address (Street	et and Number or F	Ru <i>ral Route N</i> umb	er, City or Town,		
	111811111	11111011	in-law	7	12		bine Road				797
	20a. Method of Disposition 1 ♣ Burial 2 □ Cre		Removal from State	20b. Pl	laca of Disposi emetery, crema	ition (Name of atory or other p	(ace)	Date	20c. Location -		
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State of Maryland / Department of Health and Mental Hygiene 9 07026

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al		al Security Number	6. Sex 1 M 2□				r 1 Year			8. Date of Bi (Month, De	rth .	9. Birth	place (State or Fore
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DHMH 16 Rev 6/95

Roberta Mondelione no 2005 3675

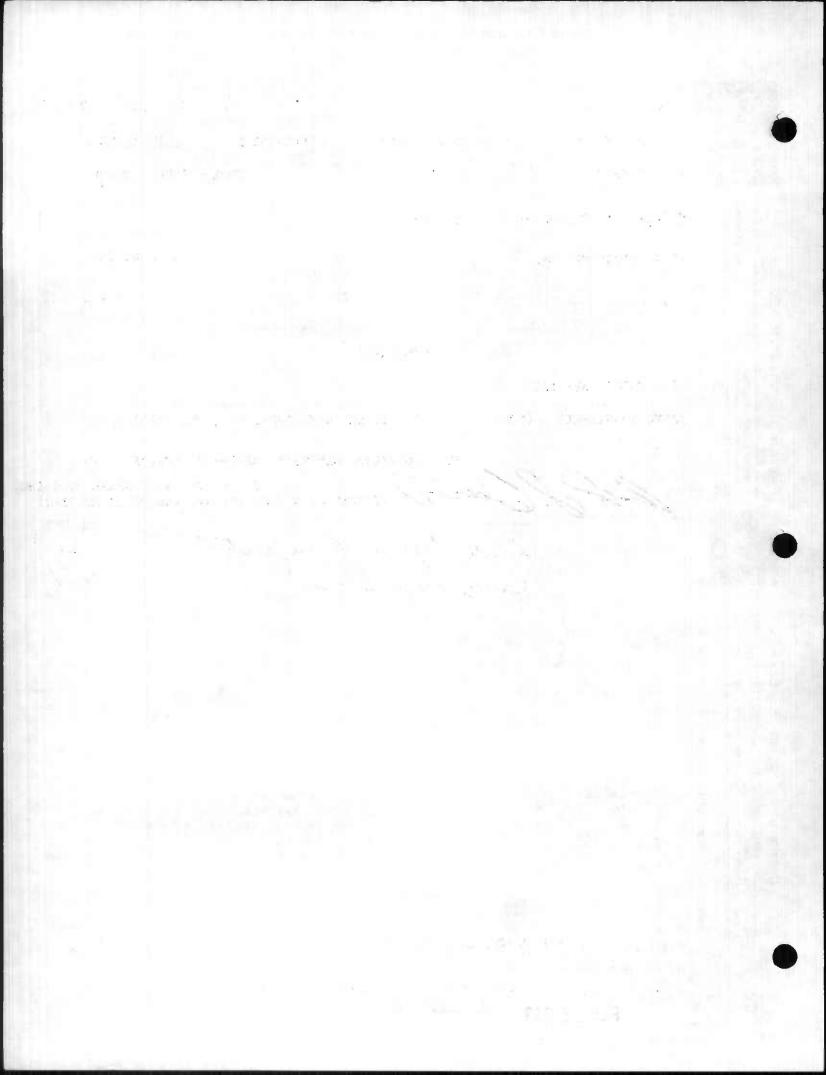
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** 15 ROWN JEAN 1925 -86 INNI+ RED /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 2 F 55 579-66-5057 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Maryler Department of Health end Mental Hydene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Experies must be nortified anones. (isti 1 XYes 2 No MD Funeral Director -omerset Eld 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21817 ANACA TUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 579-76 saltimore, Maryland 21215-0020 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 🔼 No þ Specify: 3 Widowed 4 Divorced To Be Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aborer Industry catood 17, Father's Neme (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Devald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 139th ST. 45 W 10037 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State sbuly Crematory 4 ☐ Donation 5 ☐ Other (Specify) al: P2. Name and Address of Facili Ward T. Cris unolal CONE 21817 ST not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical RESPIRATORY **Examiner** Physician/Medical Examiner CANCER LUNG MSNTH physician end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Due to (or es a consequenca of) . 68 use 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 10 2 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? peen has certificate ha 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Christural 2 | No 24 hours efter death. 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) To the F 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 3073 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury, Md. 21801 MD 18NINSUA Tuom 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 24 Registrar

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Best reb Hiam 1:15 am /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number, Examiner Glade Valley 1 Center

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If Under 1 Yeer

Days Nursing Lenie 7. Agy (In yrs. lest birthday) Walkersville If Under 24 Hrs. 8. Dat Frederick Birthplece (Stete or Foreign Country) 5. Sociel Security Number **Funeral** 10M 2□ F Year) Hours Min Months Deys 2/2-09-46// Usuel Residence of Decedent 93 **Director** the Marylend 10d. Inside City Limits 10e Stete 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23e or 28e-f ehow trsumstic event, tre Madical Examinal must be notified at 1 Yes 2 No Directo MD Walkersville trederick 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health end Mental Hygiena. 21793

13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 5. A. 14. Rece - American Indien, Street trederick 56 West Funeral 12. Wes Decedent Eyer In U,S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 11. Maritai Stetus Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) Building Laspector 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) Be Arienetta Burck Oliver 7. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Link, of Health of Item 27 ls Ijamsville MD. 2,754 ouis A. Best, 10120 Greensward 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place, Dete permit. Pages Department of Important: If It any Injury or o 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removei from State UMC Cemetery 22. Name end Address of Fecility Pritts, Funeral Home (Chapel, P.A.

4/2 Washing Ten Road

4/2 Washing Ten Road

Approximate

The first the disease, or complications that caused the deeth. Do not enter the mode of dying, such as saidlact of respiratory errest,

Approximate 4 ☐ Donetion 5 ☐ Other (Specify) 29-99 Upperco. M.V 21. Signature of Funeral Service Licensee Approximete Intervel Between Onset end Deeth **Physician** /Medical immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physician end s the bunal-transit thet the death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): d for use as t signed by the at id be datached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy should Completed page 2 hes 1 Yes 1 ☐ Yes 2 ☐ No certificeta Hospital or Attending Physician: director. 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatienf 2 ☐ ER/Outpatienf 3 ☐ DOA After this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 1 ☑ Neturei 2 ☐ Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation after death. Director: Aft 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 Homicide within 24 hours aft To the Funeral Di completely filled in Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piace, and due to the cause(s) end menner steted. Medical 29a. Certifier 5 29d. Date signed (Month, Dev. Year) 29b. Signature nd title of pertifier 29c. License number 0 rsor who completed cause of death (Item 23e) (Type, Print) KON KD filed (Month, Day, Ye 32, Registrer's Signeture State

DHMH 16 Ray 6/95

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Fabrum 18th Month **Physician** John D. Brannon 1949 1:15 ym /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Wastoninster (who to (arroll arroll and. If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1X M 2 ☐ F 83 Director 219 12 1374 Dec. 1915 N.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f ahon ns 23a or 28a-f aho Md. Carroll Sykesville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6544 Church Street 21784 U.S.A. Funerel or Items 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Peges 1 and 2 should be filed within 72 hours after marked of Health and Mentel Hyglens.

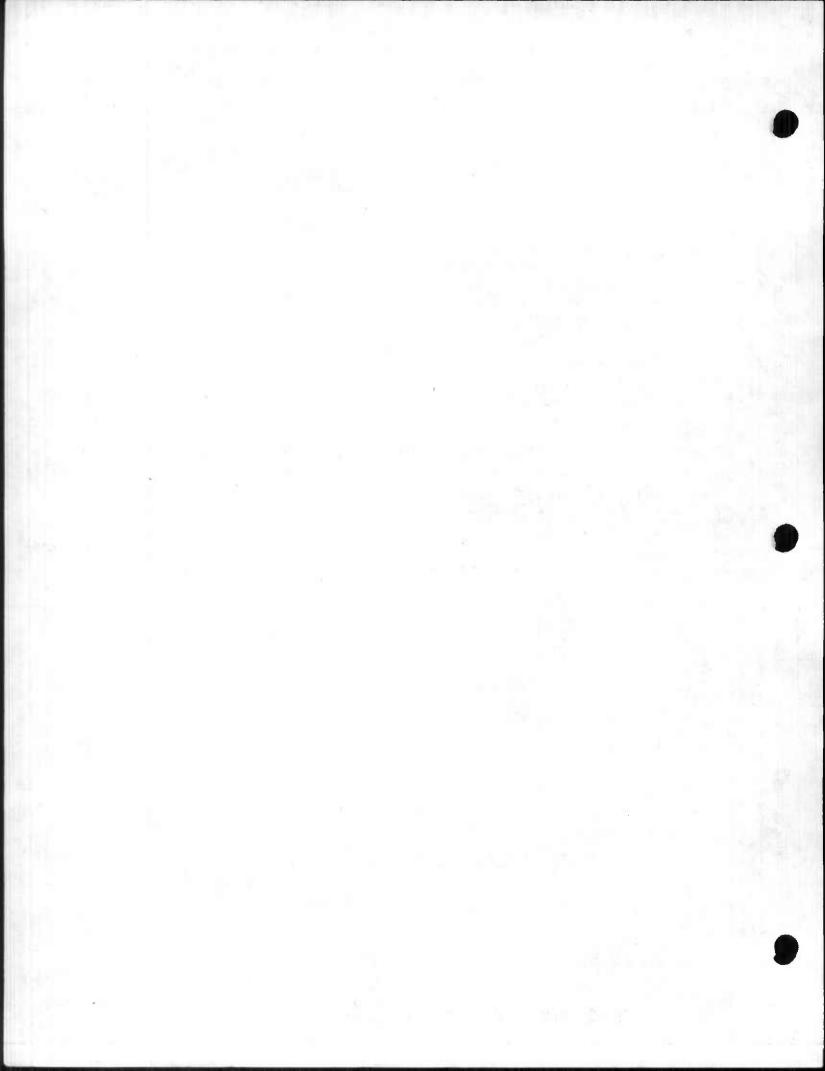
Int: If Hean 27 is marked other than *natural; or he ury or other treumatic event, the Mentel Earthin ury or other treumatic event, the Mentel Earthin 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 25 Merried Baitimore, Maryland 21215-0020 al Hygiena. d other than "natural", or event, the Medical Exact White 1 ☐ Yes 2X No Specify: Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Springfield Nurse 10 Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Riley Brannon Anna Yeargin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) Betty Lou Brannon 205 St. Mark Way Westminster, Md. 21158 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State permit. Peges
Depertment of
Important: If It
eny injury or o 1 Burial 2 Cremetion 3 Removel from State 2/22/99 Sykesville, Md. Lake View Mem. Park 4 Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Sykesville, Md. 21784 Haight Funeral Home & Chapel Box 195 23a. Part. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart leiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) and Week /Medical Examiner Failme Examiner TWO WES ona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medicel Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? on sease 1 Yes 2 No 3 Probably A Unknown 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? After this certificate has 1 Yes 2 No 1 Yes Division of Vitai or Attanding Physician: funerel director, 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 ☐ Yes 250 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b Time of 28d. Describe how injury occurred 28c. tnjury at Work? 5 Pending investigation 1 Waturat To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, lerm, street, lactory, office building, etc. (Specify) 4 Homicide 15 Pertifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and menner stated. (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) W) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 mommin MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygien 9 0 7 0 3 2

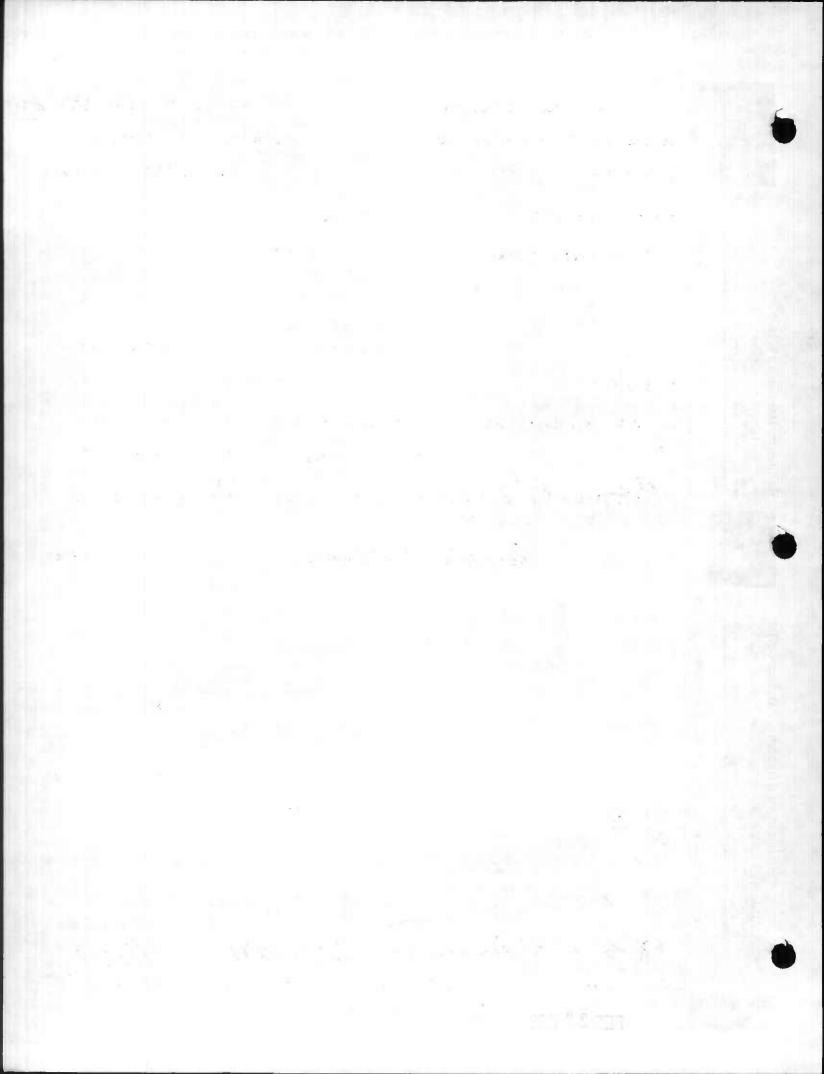
Certificate of Death

	Certificate of Death	Re	ng. No.	, 0 0 11
	Decedant's Nama (First, Middla, Last)	2. Data of Death	h	3. Tima ot Death
Physician	Mary Henrietta Brightwell	February	7 19 Yaar 7 19 199	9 95 An
/Medical Examiner	4a Facility Nama (If not institution, giva street and number) 4b. City, Town, C	r Location of Death	4c. County of Dea	ith
	Northampton Manor Nursing Home Fred	erick	Frede	rick
neral ector	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours Mi		9. Bir 7 1920	nthplaca (Stata or Foraign ountry) Maryland
H	Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Limits
	Maryland Frederick Ijamsville			1 ☐ Yas 2 🖾 No
Director	10e. Street and Number 10f. Zip Coda	10	0g. Citizen of What C	ountry?
a o ie	10415 Old National Pike 21754		U.S.	Α.
y Funeral	11. Marital Status 12. Was Dacedant Evar in U,S. Armed Forcas? 1 Navar Married 2 Married 11. Was Dacedant Evar in U,S. Armed Forcas? 1 Yas, Siva 12. Was Dacedant of Hispanic Origin? It Yas, specify Cuban, Maxican, Pu If Yas, Giva	(Specify Yas or No- arto Ricen, atc.)	14. Race - Am Black, Whi	
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Completed	15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of viida, DO NOT usa ratired)	rorking	16b. Kind ot Businass	amoustry
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Comp	17. Fathar's Nama (First, Middla, Last) 18. Mothar's N	ama (First, Middla, N	faiden Sumame)	
To Be	Rockward Nusbaum Pe	arl Starr		
-	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Routa Number,	City or Town, State,	Zip Coda)
	Dennis W. Brightwell/ son 5719 Boyers Mill Rd.	New Man	rket, MD 2	21774
To Be C	20a. Mathod of Disposition 20b. Place of Disposition (Name of camatary, cramatory or other place)	Data 2	20c. Location - City or	r Town, Stata
	W Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Mt. Olivet Cemetery	2/22/99	Frederick	, MD
once.	21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility H	artzler Fu	neral Hom	e
buce	a Harine V. Warler 11802 Liberty Rd		ytown, MD	
ical iner	Immediata Causa (Final disaasa or condition rasulting In daath) a. Constitute I fort Failure Dua to (or as a consequence of):		- 6	/mo.
n/Medical Examiner	Sequantially list conditions, if any, leading to immadiate cause. Enter Undertying Cause (Diseasa or Injury that Initiated evants rasulting in death) Last b. Due to (or as a consequence ot): c. Due to (or as a consequence of): d			
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or. p	25. Was cesa ratarred to medical 26. Placa of I	Death (Check only on	- 1	
I director.	axaminer? Magnital:		ance 8 Othar (Sp	pecify)
-	27. Manner of Death 28a. Date of Injury 28b. Tima of 28c. Injury at		ow injury occurred	
the fune cation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident invastigation M 1 Yas 2 No			
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completely filled in by the Medical Certifica	29a. Cartifliar (Check only Madical Examiner: On the basis of examination and/or investigation, in my opinion, death or	ace, and due to tha ca courred at the time, d	ausa(s) and manner a ate and place, and dr	as stated. ua to tha causa(s)
Med	one) and mannar stated.			
	29b. Signature and title of certifier 29c. Licansa number	2	9d. Data signed (Mor	/ Teal)
	D-139	17/	7/19	199
	30. Nama and addrass of person who completed ceusa of death (Itam 23a) (Type, Print)	_		21221
	Robert L. Kautmann MD 300 W. 9th St.	treder	ickmE	291,101

State Registrar 31. Data filed (Month, Day, Yaar) 32. Reg FFB 2 2 1999

2. Registrar's Signatura

G. Sparks



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year 3:00P.M Russell LeRoy Burroughs February 19, 1999 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Residence: 455 Linton Run Road Port Deposit 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) 5 Social Sacurity Number XXM 2 F Months Days 216-48-1955 52 Yrs. Dec. 5, 1946 Maryland Usual Residence of Decedan 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 ☐ Yas 2 No Port Deposit Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21904 U.S.A. 455 Linton Run Road Funeral 12. Was Decedent Ever In U.S. Armed Forcas? ₹CXYes 2 □ No If Yes, Give Yaar or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XIX Married 1 Yes XXNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry Aberdeen Proving Ground 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+)
Four Years Federal Credit Union Elementary/Secondary (0-12) Purchasing Agent Bel Air, Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17 Fethar's Nama (First, Middle, Last) Be Ormond Russell Burroughs Maryanna Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Cheryl S. Burroughs (wife) 455 Linton Run Road, Port Deposit, Maryland 21904 20b. Placa of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Nottingham Missionary Baptist 1 Burial 2 Cremation 3 Ramoval from State 2/22/99 Nottingham, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 21. Signature of Funeral Service Liberar 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Perryville, Maryland 21903-0188 Approximate Interval Between Onsat and Death Metas tatic minory Bladder Canan Immediate Cause (Final diseese or condition resulting in death) Dua to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of): Dua to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown End stage Roual disease by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy Completed Atheroscherotic Cardio Vescular discere Diabeter Mellitus Insulir reguling 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ona) Be 25. Wes case referred to medical axaminer? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760,

requires that the death certificate be executed

Physician

/Medical

Examiner

Directo

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 Is marked other than "natural", or items 23s or 28s-f show any injury or other treumstic event, the Medical Examiner must be notified at

Physician

/Medical

Examiner

physicien and the burief-transit

80 use

Examiner

Physician/Medical

Baltimore, Maryland 21215-0020

signed t page 2 certificate or Attending Physicien: After this efter death. Director: Aft 24 hours e Hospital

To the

+ IVA

State

Registrar

funeral director,

filled in by

Medical

29a. Certifier

(Check only one)

Certification: To

within 2

29b. Signature and title of certifier. ahed Kon M-D 29c. Licanse number D48271

suite 203

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

MI

21204

Towson

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

Kou II FAHED Drive 7600 Osler

32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Di visto		1. Decedent's Name (First, A	liddle, Las	st)						2. Date of Do	eath Day	Year	3. Time of Death
	Physicia /Medica	_	Ruth E. Buck	ingha	m						FEBRUA		1999	1344
	Examine		4a Facility Neme (If not instit	ution, giv	e street end nu	m <i>ber)</i>				4b. City, Town, or			y of Deeth	
		3	Union Hospita	l						Elkton		C	ecil	
	Funeral Director		5. Social Security Number 221-09-0048		ex □M 2 X)F	7. Age (In yrs. 86	last birthday Yrs.	Months	1 Year Days	Hours Min.		ey, Year)	Cour	place (State or Foreign http) Yland
	pue **	1	Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	y, Town or L	ocation					1	Od. Inside City Limits
	Mary	ō	Delaware New	· Cas	+00	Mai	vark							1 X Yes 2 □ No
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	3a or	<u> </u>	12B Independe	n o o	Cinolo			197	711			USA		
	death	Jera	11. Marital Status	nce	12. Was Dec	edent Ever in U	.S. 13		_	lispenic Origin? (S en, Mexican, Puer	Specify Yes or N		ce · Americ	
21215-0020	within 72 hours efter death with the Maryland ene. than "natural", or frems 23a or 28s-f show he Madistel Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ 3 🛱 Widowed 4 ☐ Divo		Armed Fo 1 ☐ Yes If Yas, Gir Year or D	21X No		1 Yes, spec			to Hican, etc.)	Specia	ock, White, fy: WH	etc. ITE
2-0	72 ho	ted	15. Dece (Specify only h	dent's Ed	lucetion		16a. Dec	edent's Usua	I Occup	pation	rkina	16b. Kind of E	Business/Inc	dustry
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Jar	2 she no		19a. Informant's Name/Rele							end Number or R				Code)
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Baltimore,	Pege nent o ant: If i		20a. Method of Disposition 1 Burial 2 Cremat 4 Donation 5 Other			State	emetery, cr	emetery or or emeter	ther ple .Y		2-22-99	Newark		
Balt	pemit. Pe Departmen Important: any Injury once.		21. Signature of Fulheral Ser	vice Licen	1 do	lo.	Ŕ	22. Name and	d Addre	ess of Focility d Funera en St.,	l Home,	P. A.	2191	1
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	To the Hospital or Attending Physician: The i within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical			niner: On the b					me, dete and plac opinion, death occ				
	withir To th	M	29b. Signature and title of ce	rtifier	1			290	. Licen	se number		29d. Dete sign	ed (Month,	Dey, Year)
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	17		30. Name and address of per		completed ceus	se of death (Iter	n 23a) (Type	e, Print)						
	12	1	MARTIN F. GAN		DO A	-940	MEGA	DRIVE	- 1	EWARK .	DE			
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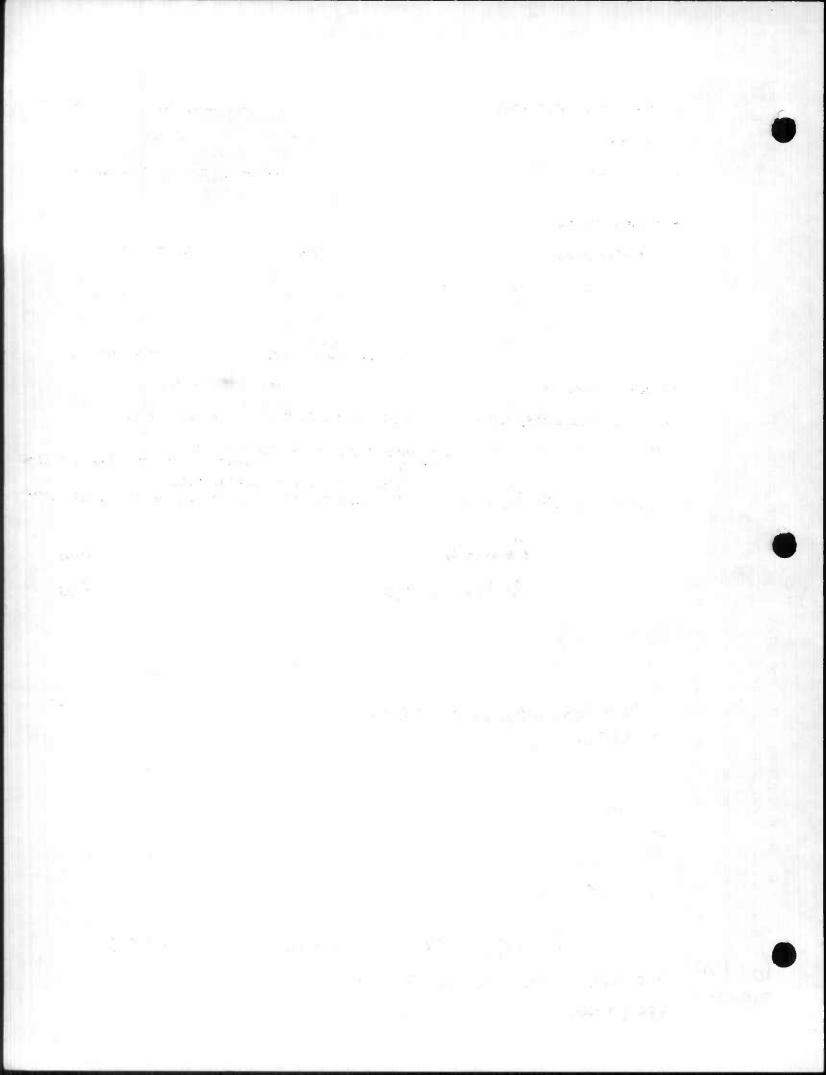
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State of Maryland / Department of Health and Mental Hygiene 9 0 7 0 3 5

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician-HOWARD ERNEST BISHOP FEBRUARY 21, 1995 272/ /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/8/29 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**♥** M 2□ F 215-26-5831 MD Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limita 10b. County s 1 and 2 should be filed within 72 hours after death with the Manylan I Health and Mental hygiens. I the first 23a or 28a-f show other traumatic event, the Medical Evantive mainton notified as other traumatic event, the Medical Evantive mainton notified as 1 ☐ Yes 2 🕱 No Directo Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8038 Purnell Crossing RD 21811 USA Funeral 12. Wes Decedent Ever in U.S.
Armed Forces? War

1 15 Yes 2 □ No
If Yes, Give Korean
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. 11. Marital Status 1 Never Merried 3 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: white by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Farmer Poultry Grower 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles H. Bishop Alberta Hastings 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health & Barbara Bishop/ Wife 8038 Purnell Crossing RD Berlin, MD 21811 altimore. 20b. Place of Disposition (Name of cemetery) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 6 Department of Important: If any Injury or price. Oak Hall Riverside 2/25/99 Libertytown, MD 4 ☐ Donation 5/☐ Other (Specify) 22. Name and Address of Fecility Burbage Funeral Home 108 William St. Berlin, MD 21811 to complete his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, that cause on each line. Approximate interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Chamic attending physician and for use as the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or es a consequence of) P.O. Box 68760, 11102 Physiclan/Medicai Due to (or es e consequence of) igned by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Insulticion Division of Vital Records, by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s has 21 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical exeminer? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28d. Describe how Injury occurred 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 Naturel 2 Accident s after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide Hospital 24 hours Tirtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

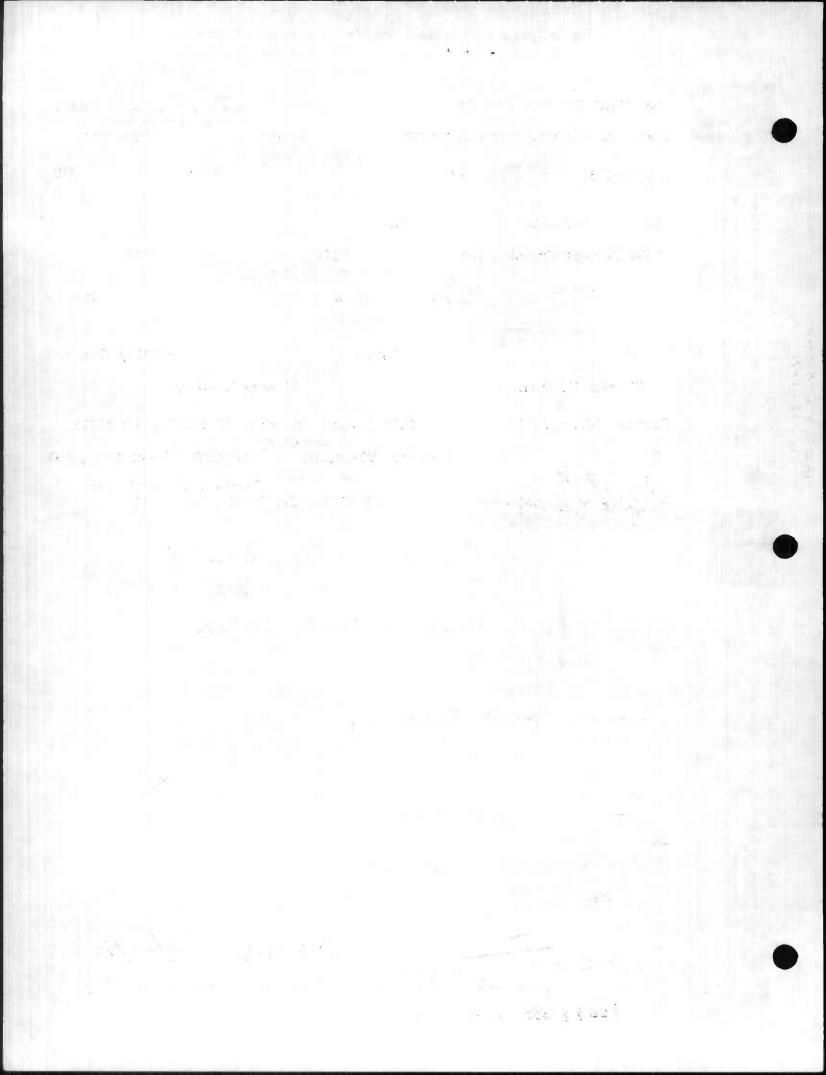
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) WW Ewian Heave am 31. Date filed (Month, Day, Year) 32. Pégistrar's Signature State 2 2 1999 Registrar

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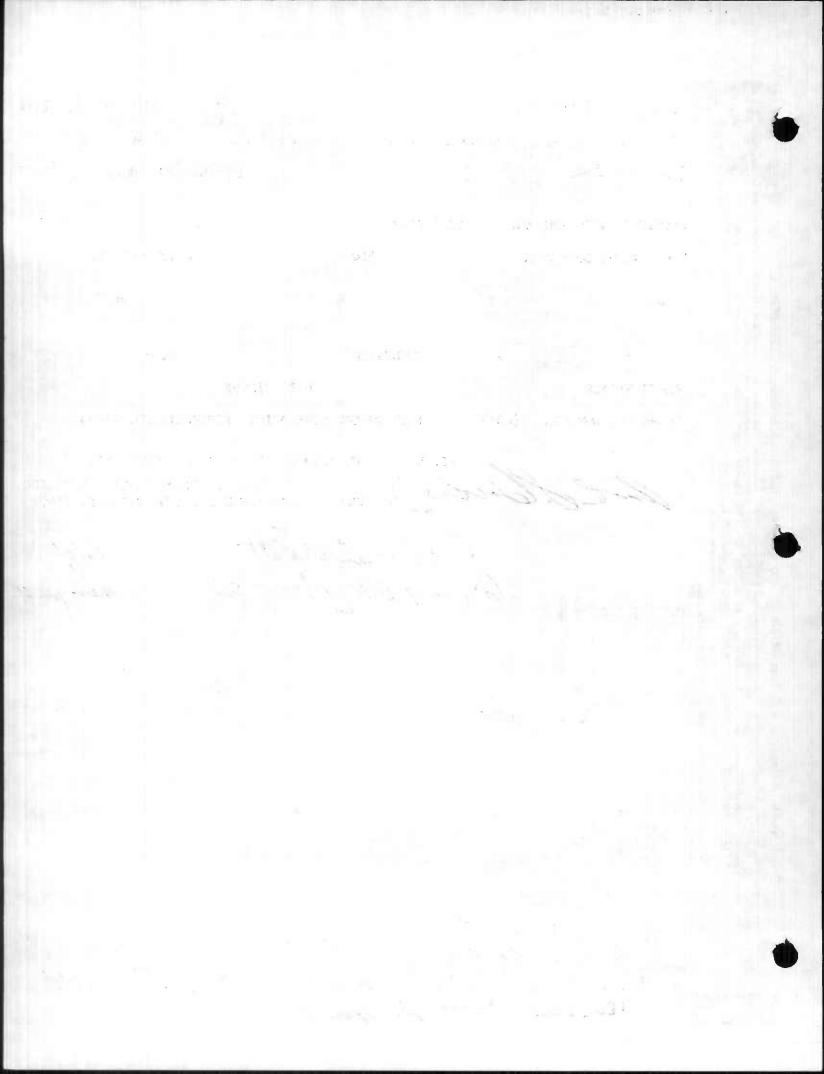
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3 Time of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) Month 45 **Physician** borre Ili Va pm 02 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Annapolis Nursing and Rehab Center 5. Social Socurity Number 6. Sex 7. Ago (in yrs. last birthday) If Undo Annapolis If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (State or Foraign Country) **Funeral** 096-22-5652 1 M X F Egypt -02-09 Alexandra, Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or ferms 23a or 28a-f show traumatic svent, the Medical Exercises must be notified at the Maryler 1 ☐ Yes 2 No Directo MARYLAND ANNE ARUNDEL ANNAPOLIS 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21403 UNITED STATES 1520 GORDON COVE DRIVE Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status should be filed within 72 hours after nd Mental Hyglena. marked other than "natural", or ite 1 Yes 2 No
If Yes, Give
Yaer or Detes: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: Specify: WHITE Aq 3 □ Widowad 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 HOMEMAKER HOME 17. Fethar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) h and Mental SANTO MICALE ROSE SIMONE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health a Important: If Item 27 is any Injury or other trai once. 1520 GORDON COVE DRIVE ANNAPOLIS, MD. 21403 ROBERT P. BORRELLI (SON) 20b. Plece of Disposition (Neme of cematery, crametory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) FT. LINCOLN CREMATORY 02-14-99 BRENTWOOD, MD. 2. Name end Address of Fecility JOHN M. TAYLOR FUNERAL HOME, INC. 47 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD. 21401 Approximate Interval Between Onsat and Death 23a. Pert1. Enter the diseese, or complications that caused the death shock, or heart feilure. List only one cause on each line. Do not enter the mode of dying, such es cerdiec or respiratory errest, **Physician** Immediete Ceuse (Finel disease or condition resulting in death) /Medical Examiner Examiner physician end s the buriel-transit Sequantielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury certificate be Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of): 80 esn to 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. datached 3 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, 8 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to Completed Deen completion of causa of deeth? certificate has 1 Yes 2 No 25. Wes cese referred to medicel exeminer? Be 26. Piece of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28d. Describe how Injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? Certification: After Attending 1 Neturel 5 Pending death, 2 No 1 Yes investigetion after death 2 Accident 6 ☐ Could not be determined Location (Street end Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide To the Hospital within 24 hours To the Funeral Hospital 29e. Certifier 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date and plece, end dua to the causa(s) and mannar as steted. edica completely 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertification 29c. Licansa number (Item 23a) (Type, Print) Hot B 1 6 State 1999 Registrar

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Nama (First Middle Last) 2. Data of Daeth 3. Time of Death 0335 106 JAMES E. BOOTH JR. 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nama (If not institution, give street and number) DEATON UNIVERSITY OF MARYLAND MEdicINE BAITIMORE If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax Birthplace (State or Foreign Country) M 2□ F 217-38-9784 FEB 6 1941 MARYLAND Usual Rasidance of Dacedant 10c. City. Town or Location 10d. Insida City Limits 10a. Stata 10b County 1 Yes 2 No MARYLAND NONE BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3330 SAINT AMBROSE STREET 21215 US Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedant Ever in U.S. Armed Forcas? 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yas 2 🛣 No If Yas, Give 1 Navar Marriad 2 Married 1 ☐ Yas 2 No Specify: Specify: 3 ₩Widowad 4 Divorced BLACK Year or Dates: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) BROADWATER BOAT CO. 12th 0 PAINTER 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Surnama) JAMES E. BOOTH SR. HENRIETTA DORSEY 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e Informent's Name/Ralationship (Type, Print) JAMES E. BOOTH SR. (FATHER) 5 HICKS AVE. ANNAPOLIS, MD. 21401 20b. Placa of Disposition (Nama of 20c. Location - City or Town, State 20a. Mathod of Disposition Data crematory or othar placa) 1 ★ Burial 2 Cramation 3 Ramoval from Stata ANNAPOLIS MEM. GARDENS 2/18/99 ANNAPOLIS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensaa 22. Name and Address of Fecility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disaasa, or complications thet caused the daath. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Ceusa (Final ARDING HERRY Thinks 6 munitos diseese or condition rasulting in deeth) Moult Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disaase or injury that initiated avants rasulting in daath) Last Dua to (or as a consaquanca of): 1 woll the Sucephalo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? 1 Yes 2 No 3 Probably Munknown 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yas 1 Yas 2 No 25. Was casa referred to medical exeminer? 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Inpatiant 2 □ ER/Outpatient 3 □ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

7 is marked other traumatic event, in

If item 27 or other tr

Director

Funeral

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Completed

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Pages 1 and 2 should be need of Health and Ment

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Examiner physician and the burial-transit Physician/Medical signed by the a been si page 2 s certificate director.

that the death certificate be axecuted Division of Vital Records. or Attending Physician: this funeral After death. Director: A

by Completed Be Certification: To

Medical

27. Mannar of Death 1 Naturel 2 Accident

(Check only one)

29a. Certifier

5 Panding Invastigetion 6 Could not be determined 3 Suicida 4 Homicide

28a. Data of Injury (Month, Day Year)

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28b. Tima of

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifiar

29c. Licanse number DU 1346

29d. Data signed (Month, Day, Year)

esta tymes 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) DENTION STELLETY HOSPITAL Kus)

32. Redistrar's Signatura

by South aurles St. Balturoxe21230

State Registrar

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2:25Pm Martin J. Barrett Hebryany /Medical 4a. Fecllity Neme (If not institution, give street end number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Gien Burnie Anne Arundel Hospital trunde If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 194-18-4098 1 M 2 □ F 73 Director July 6, 1925 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No NJ Camden or 28a-1 Glendora 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 319 Keller Road Items 23a 08029 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give 1943-46 Year or Dates 1943-46 1 ☐ Never Merried 2 ☑ Married b 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than the Philadelphia Gas Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Foreman Works 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Health and Mental 7 is marked of traumatic ev Martin J. Barrett, Sr. 10 Lillian Krebs Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Keller Road, Glendora, NJ 08029 Marie D. Barrett / wife Important: If them 27 any injury or other to 20a. Method of Disposition 20c. Location - City or Town, State Department of Feb 16 Springfield, PA 4 Donation 5 Other (Specify) 1999 22. Name and Address of Facility Barranco & Sons, PA. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 Approximate Approxi Interval Between Onset and Death **Physiclan** LIVER Immediete Ceuse (Final disease or condition resulting in death) /Medical CIRRHOSIS THE Onzens **Examiner** Due to (or es e consequence of) Examiner The law requires that the death certificate be executed burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of) Box 68760. Physician/Medical the Due to (or as a consequence of) USB P.O. Pert II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, by paga 2 should Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manufer of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? al or Attending F s after death. Il Director: After ed in by the funer After Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 24 hours Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completaly fi (Check only

29c. License number

29d. Date signed (Month, Day, Year)

DRIVE, GLOW BURNE, UND . 21061.

State Registrar one)

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

FEB 1 6 1999

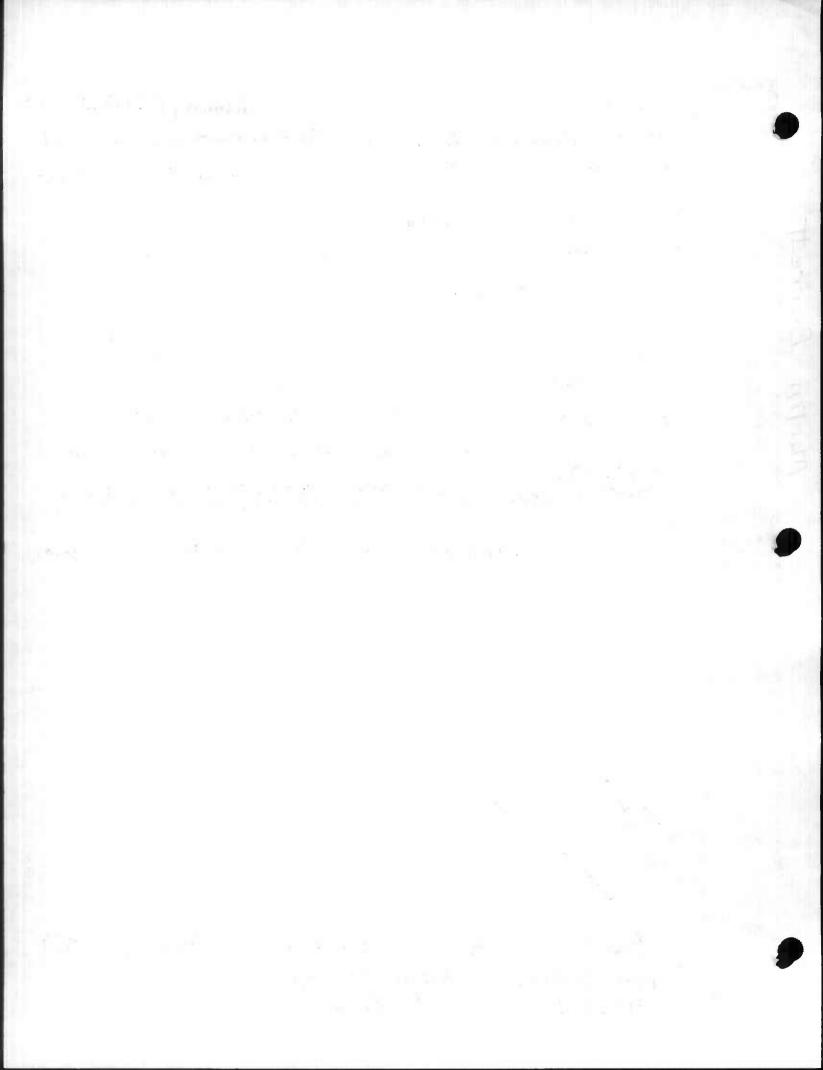
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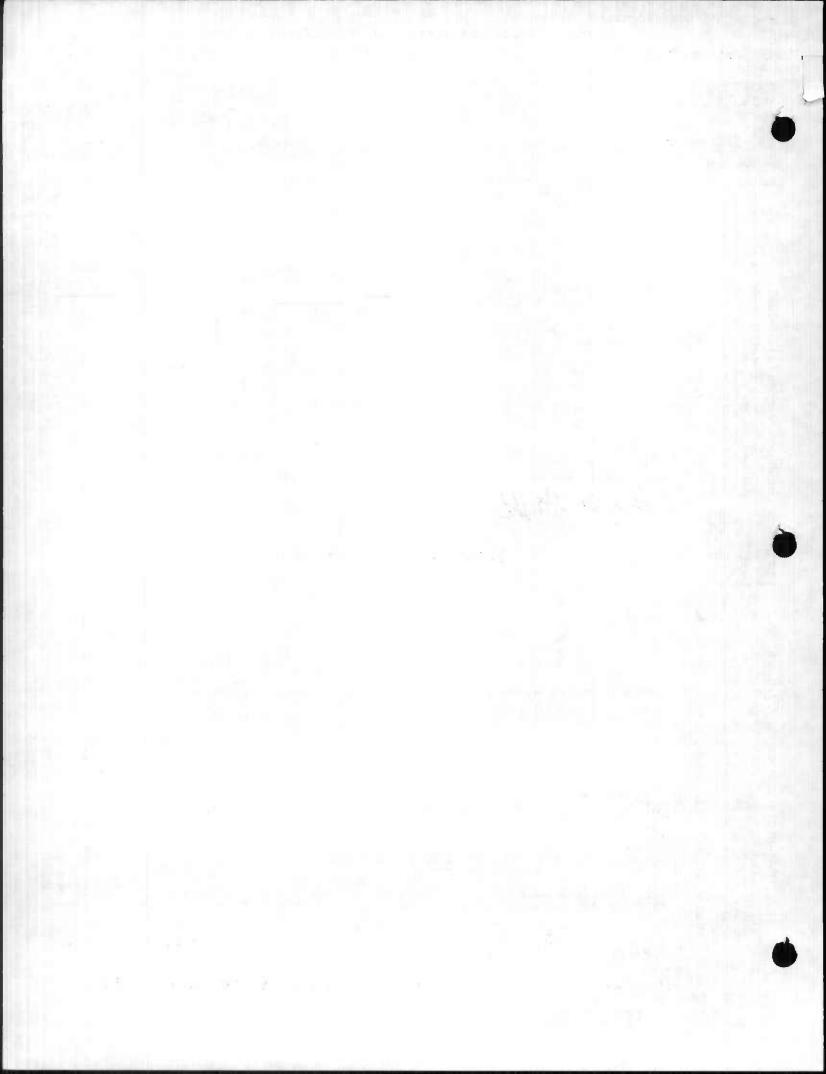
3. Registrar's Signature

Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

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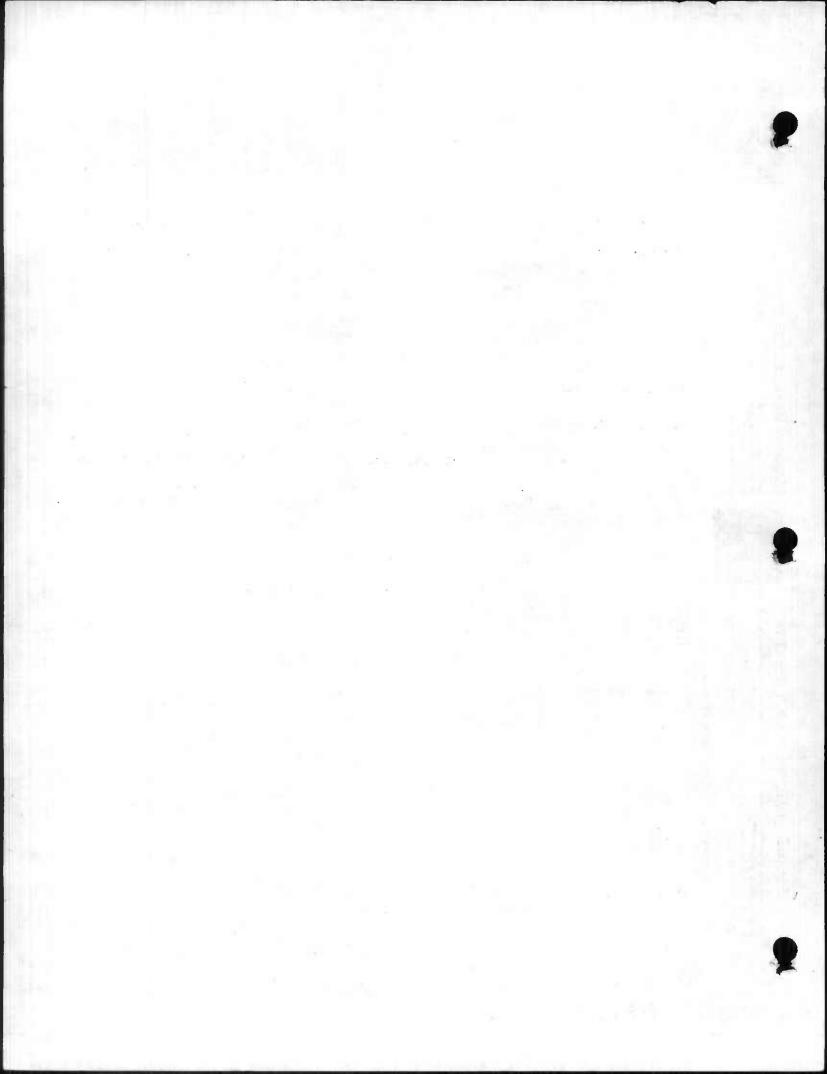


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Certifi	icate of	Death	R	leg. No.	U	1041	
	1. Decedent's Name (First, Middle,			2. Date of Dea Month			3. Tima of Death				
Physician /Medical	Eleanor C. Clay				Februar	February 18, 199		1400			
. Examiner	4a Facility Name (If not institution,		4b. City, Town, or L	ocation of Death	4c. County	of Deeth					
<i>S</i>	Laurelwood Conti	nuing Care	e Center			Elkton	on Cecil				
Funeral Director	5. Social Security Number 217-20-9565 6. Sex 1 Morths Days Hours Min. 1 N 225 F 91 Yrs.							8. Date of Birth (Month, Day, Year) nber 9, 1907 8. Birthplace (Stete or Country) Maryland			
p >	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
aryle about	10a. State 10b. County				*1				1"	0d. Inside City Limits 1 No 2 No	
vith the Ma or 28a-f a be notified Director	Maryland Cecil 10e. Street and Number		Elkto		Of, Zip Code		1.	IOn Citizen of 1	Affron Cour		
isr deeth with the Marylen items 23a or 28e-f showner matt be notified at unersi Director			10g. Citizen of What Country? United States								
020 ura est by F	3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1	s? ☑ No		Decedent of I s, specify Cut Yes 2 XNo	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Ble	e - Americ ck, White, White		
72 hours 'natural',	15. Decedent's (Specify only highest)		16a	Decedent's	Usual Occu	pation during most of work	ina	16b. Kind of B	usiness/Inc	Justry	
Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. DO N	IOT use retire	d)					
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D EIBS .	17. Father's Name (First, Middle, La	st)				18. Mother's Nam					
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Marylg d 2 should th end Mer 7 la marke treumætic	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Ad	ddress (Stree	t and Number or Rui	ral Route Numbe	r, City or Town,	State, Zip	Code)	
re, N 1 and 1 1 Heelth 1 Heelth 1 Other tr	R. Eugene Clay/	Son	000	of Discoulities	Alama of	Road, Elk					
The state of the s	20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20b. Location 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location 20c. Location									, Maryland	
Balti permit. P Departm importan eny injur	21. Signature of Funeral Service Lic	ensee		Hick	s Home	for Fune			22112	nd 21021	
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that cause	sed the death. Do						aryra	Approximete	
Physician	shock, or heart failure. List on	ly one cause on each	ine.						1	Interval Between Onset and Death	
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) a. ATMAL ENAMED TO BE DUE to (or as a consequence of):										
i i	All of the second	11000				THE WALL	10000		1	24.61	
axecuted on end fel-transit Examiner	Cause (Disease or injury that initiated events pue to (or as a consequence of): Due to (or as a consequence of):									0 0000	
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	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.							23b. Did tobacco use contribute to the cause of			
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							24a. Was o		CO	ere autopsy findings allable prior to mpletion of cause deeth?	
The law ate has page 2							10Y	es 20 No	1	Yes 2 No	
certificate rector, pag	25. Was case referred to medical					26. Place of Dee					
Physician: This certificital director, To Be (1)	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2 ER/O	utostient 3	DOA O		ome 5 Resid		er (Specif	v)	
Invision of vital of attending Physician: 7 afterdeeth. Jin by the funeral director, for	27. Manger of Death 1 Natural 5 Pending 2 Accident investigat	28a. Data of li (Month, i		Time of Injury	28c. Inju	ry at ork?	28d. Describe h			<i>N</i>	
DIVISION C be or Attending P as after death. al Director: After t ed in by the funera Certification:	3 Suicide 6 Could not determine	200. Place of	Injury - At home, f etc. (Specify)	arm, street, f	factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,	
To the Hospital or Attending Physician Carbon As house that death, completely filled in by the tuneral completely filled in by the funeral Medical Certification: 7	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be- aminer: On the basis and manner	of examinetion as	e, death occ nd/or investig	curred et the togation, in my	ime, date end place, opinion, deeth occur	end due to the o	ause(s) end m late and plece,	enner es si and due to	lated. the cause(s)	
within Within To the compi	29b. Signature and title of certifier				29c. Licen	se number	1	29d. Dete signe	d (Month,	Day, Year)	
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5	30. Name and address of person wh	o completed cause of	death (Item 23a)	(Type Print)	1405		- (7 -	71001	
-	Rolando A 31. Date filed (Month, Day, Year)	. Najera	strar's Signature	() ()	W. H	high Stra	eet Sui	te 214	Elk	21921 (ton mD	
State Registrar	FEB 1 9 1999	1 0	a G	10	21						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death 3. Tima of Death Month **Physician** 2 23 MARY KATHERINE COLLINS /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Atlantic General Hospital Worcester Berlin If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/27/23 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10M 2KF Months Days Hours Min Yrs. 75 216-16-7460 MD Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fahov 7 is marked other than "natural", or items 23s or 28s-f sho traumstic event, the Wed cal Examiner must be notified as MD Worcester Berlin Yes 2 No Directo 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 114 Cedar Ave. 21811 USA Funeral 72 hours eftar death 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 3 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Maryland 21215-0020 1 ☐ Yes 2 No Specity: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within? Department of Health and Mental Hygiene. Important: if item 27 is marked other than "eny injury or other trearmatic event, in the Elementary/Secondary (0-12) College (1-4or 5+) 12 Town Government Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Bryan D. Schoolfield Leona Blades 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Raletionship (Type, Print) Clayton P. Collins/ Husband 114 Cedar Ave. Berlin, MD 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State **Evergreen Cemetery** 2/26/99 Berlin, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD of complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, List only one cause on each lina. Approximate Intarval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical myocan **Examiner** Due to (or as a consaguenca of) Examiner and I-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last Due to (or as a consequenca of) physician ar Physician/Medicai Due to (or as a consequenca of): 80 ettending law requires that the death 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 6 1 Yes 2 10 3 Probably 4 Unknown À 24b. Wera autopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Was casa rafarred to madical examiner? 26. Placa of Daath (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: or Attending 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident Director 6 ☐ Could not be 3 Suicide 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowladga, daath occurred at the time, date and placa, and dua to tha cause(s) and manner as stated. edical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the causa(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and eddress of person who completed cause of daath (Itam 23a) (Type, Print) 10 Berle 97 33 Hezi

32. Registrer's Signeture

DHMH 16 Rev 6/95

State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth Month Veer GARDNER CORBIN 02 23 99 1136 SR

4b. City, Town, or Location of Deeth

4c. County of Deeth

Physician /Medical Examiner

4e. Fecility Neme (If not institution, give street end number)

Funeral Director

the Maryland r 28a-f show "natural", or items 23a or death

Peges 1 end 2 should be filed within 72 hours after or and of Heelih and Mental Hygiene. int: if Ilem 27 le merked other then "natural", or iter iny or other traumatic avent, in Menical Expansion Baltimore, Maryland 21215-0020 permit. Peges Department of Important: If It any injury or o

Physician /Medical Examiner

Box 68760.

P.O.

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Division of Vital

Examiner bunial-transit The law requires that the deeth certificete be executed physician Physician/Medical the 80 for use signed by the et by Completed has page 2 certificate or Attending Physician: director. Be Certification: To this funeral After 24 hours after death.

Funeral Director: A the completely filled in by Hospital Medical within 2 To the ŝ

PENINSULA REGIONAL MEDICAL CENTER SALISBURY

If Under 1 Yeer | If Under 24 Hrs.

Months Deys Hours Min. WICOMICO 5. Social Security Number 6. Sex 1FIM 2□ F 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months 215-20-0413 Vrs Virginia 05-14-27 Usuei Residance of Decedant 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Director Worcester Pocomoke City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2109 By Pass Road 21851 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

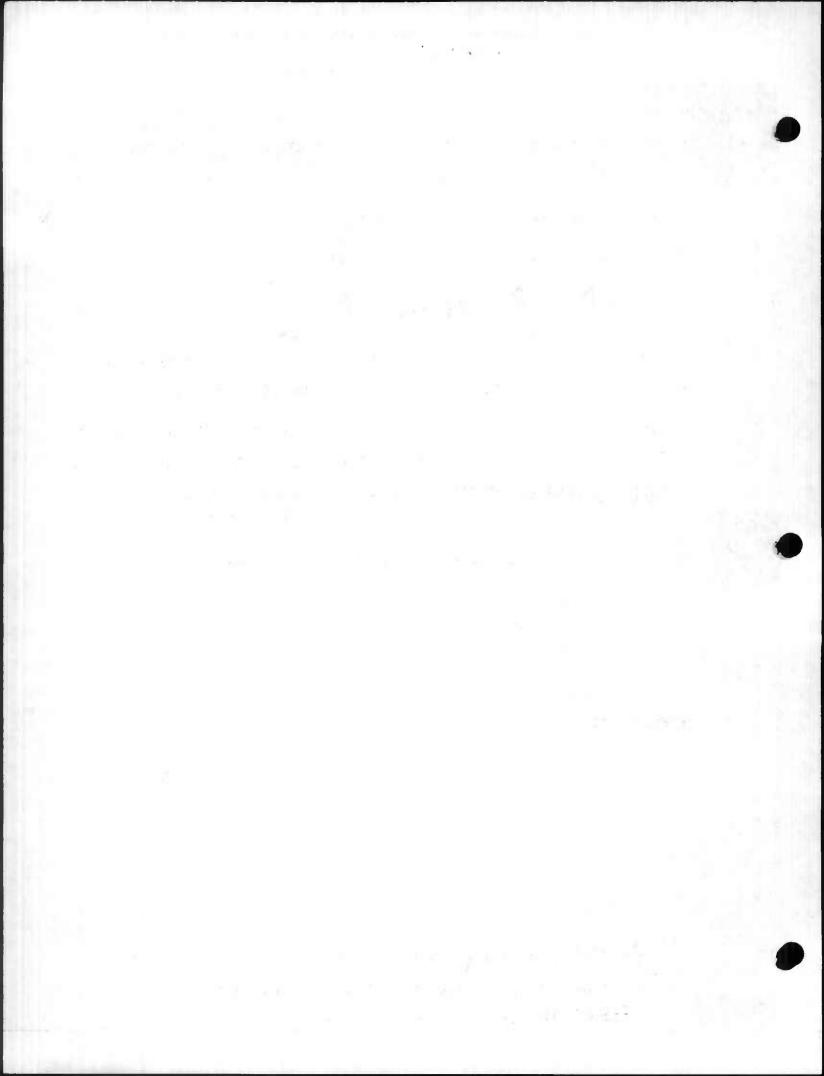
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If Yes, Give
Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 12 Management Manufacturing 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be Ralph Corbin Eva Virginia Gardner 19a. Interment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) James G. Walker (Son) 103 Crescent St. Tabor City, NC 28463
lece of Disposition (Neme of Dele 20c. Location - City or Town, Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Bunal 2 Cremetion 3 Removel from Stete Donetion 5 ☐ Other (Specify) First Baptist Cem. 2/26/99 Pocomoke, MD21851 22. Neme end Address of Fecility 21. Signeture of Fungrel Service Licensee ADean m61129 Holloway Melson F.H.103 Linden Ave 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respire to the shock, or have failure. List only one cause on each lina. Approximete Intervel Between Onset end Death Immediate Ceuse (Final diseese or condition resulting in deeth) . ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or es e consequence ot): Sequantially list conditions, if any, leading to Immadiata causa. Enter Underlying Ceuse (Disaase or Injury thet initiated avants resulting in deeth) Lest Due to (or as e consequence ot): Due to (or es e consequença ot) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPERTENSION 24b. Were autopsy tindings eveileble prior to completion of cause of daath? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case rafarred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☒ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Panding Investigetion 1 X Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28t. Location (Street end Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, tarm, straat, tectory, office building, atc. (Specify) 4 Homicida 29a. Certifier 1 Certifying Physician: To the best of my knowledga, deeth occurred et the time, deta end plece, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dev. Year) 30. Name and eddress of person who completed cause of dauth (Item 23a) (Type, Print) D0003599 02-23-99 JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year) FEB 2 5

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Death 3. Time of Deeth 1 Decedent's Nama (First, Middle Last) Month **Physician** FEB. 1999 TAMIKO CLAY 11 12:49 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner SUITLAND 3518 SILVER PARK DRIVE GEORGE PRINCE | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | MARCH 7 1968 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MARYLAND Months 1□M 2√2 F Yrs 30 Director 215-06-6218 Usual Residence of Decedent with the Merylend 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Itsm 27 is marked other than "natural; or items 23s or 28s-f show other trsumetic event, the Medical Examiner must be notified at No Yes 2 No Directo MARYLAND PRINCE GEORGE SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 US 3518 SILVER PARK DRIVE Funeral death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forcas?

1 Yes 2 No
If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours aftar c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural; or iten any injury or other traumatic event, the Medical Example. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK py 3 ☐ Widowed 4 ☐ Divorced Yaar or Datea Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SADIES HAIR BEAUTICIAN 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middia, Last) Be PHYLLIS PIERCE WILLIAM JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1318 CHAPEL VIEW DR. ODENTON, MD. 21113 PHYLLIS JOHNSON (MOTHER) 20b. Place of Disposition (Neme of cematery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removal from State MD. NAT. MEM. PARK 2/15/99 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. - eese 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD • 21 4 0 1 Approximate the shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Inmunie Deficiecy Syndrome Examiner Examiner physician end s the burial-trans Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in daath) Last Due to (or as a cons certificate be exec Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequenca of): as esn Po 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 3 Probably 4 Unknown 1 Yes 2 No þ 2 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? peeu hes page 2 250 NO 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Be 25. Was casa referred to madical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

director 2 funerel Certification:

1 ☐ Yes 2 No 27. Manner of Deeth Natural 2 Accident

3 ☐ Suicide

4 Homicide

5 Pending invastigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of cartifier

29c. License number

29d. Data signed (Month, Day, Year)

20785

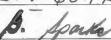
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) renkataraman Chandar

State Registrar

Medical

31. Date filed (Month, Day, Year)





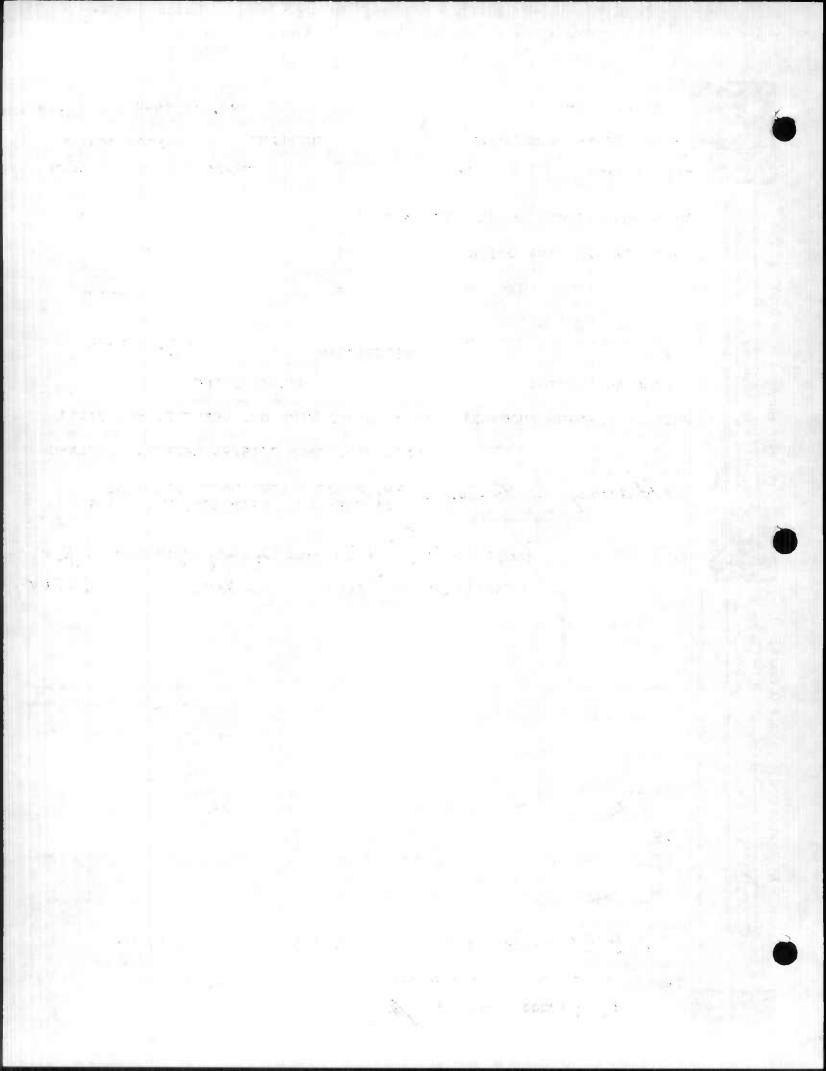
After this

after death.

2

Attending

the Hospital or within 24 hours To the Funeral



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) CHAPPELL Month **Physician** MARY February 13, 1999 7:50 P.M. ' /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Yeer If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 1□ M 2□ F Months Days Yrs Director 578-34-8750 69 June 2, 1929 Maryland Usuat Residence of Dacedant the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. fnsida Clty Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ♥ Yes 2 No Director Maryland Anne Arundel Annapolis 10g. Citizen of Whet Country? 10e. Street end Number Of, Zip Coda 910 Shipmaster Court 21401 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status 1 Tes 2 No
If Yes, Giva
Yeer or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ♥ No Specify: Specify: White P 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiena. ther than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filled with Department of Health and Mental hygient important: if Item 27 is marked other that any Injury or other traumatic excepts. 12th Supervisor Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Erich Alfred Gebhardt Mary Ann Kiplinger 19a. Informent's Neme/Reletionship (Typa, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Guilford Chappell/ Husband 910 Shipmaster Court Annapolis, Maryland 21401 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Othar (Specify) Lakemont Mem'1 Gardens 2-16-99 Davidsonville, MD uner Levice Licensee 21. Signature 22. Name and Address of Fecility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23e. Pert1. Enter the diseese, or complications that causad the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final RESPIRATORT PALLURE disease or condition rasulting in death) Examiner CHRONIC PALLUXE VENTLYDUT burial-transit Sequentielly list conditions, if any, laading to immediate causa. Entar Undarlying Ceuse (Disease or Injury that Initiated evants resulting in deeth) Lest and physicien s the burial Box 68760 Physician/Medical Due to (or es e consequence of) WING XSTRUCTIVE attending P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown signed by t RHEUMATOD 1 Yes 2 No Records. by 24b. Were eutopsy findings eveilabla prior to completion of cause of death? Completed 24a. Wes en eutopsy KYPHO80Wasil 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medicel exeminer? Be 28. Pleca of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA Certification: To this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 ☐ Yas 2 No 2 Accident 6 Could not be detarmined 3 Sulcide Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) in by 4 Thomleide Certifying Physician To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the causa(s) and mannar es stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and placa, and dua to the cause(s) end menner statad. edical 29e. Certifier 29b. Signature and title of confi 29d. Date signed (Month, Dey, Year) 29c. License number 30. Nama and addrass of parson who completed cause of daath (Itany 23a) (Type, Print) KELT NE ANNA, HOLLE

State

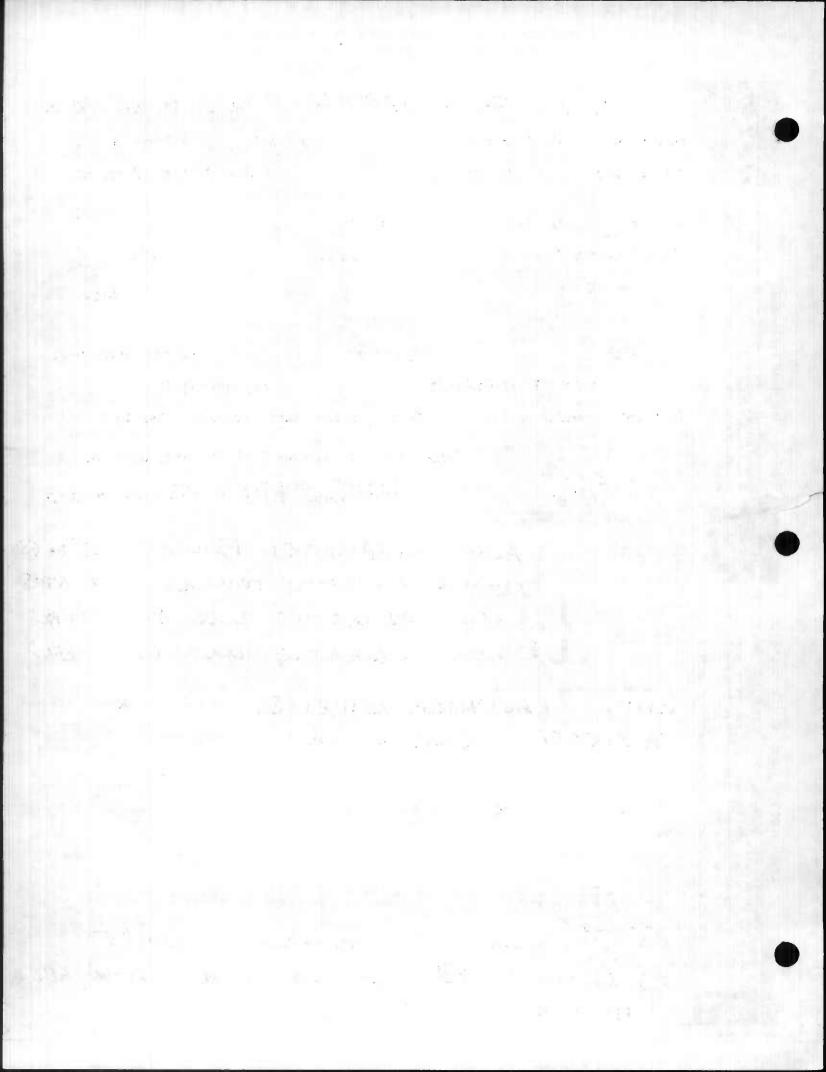
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FEB 1 6 1999

31. Dete filed (Month, Day, Year)

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32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3. Tima of Death 1. Decadent's Nama (First, Middla, Last) 2. Date of Daath 17 1999 CLOSS SR. Feb. 10:30pm THOMAS HALSEY 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Annapolis Anne Arundel Genesis Eldercare Spa Creek If Under 1 Year If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Yaar) 7. Age (In yrs. last birthday) Days M 2□ F 104-05-5593 May 11, 1911 New York Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Anne Arundel Annapolis 10f. Zip Coda 10g, Citizan of What Country? 10e Street end Number 21401 U.S.A. 951 Shadewater Way Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armad Forcas? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status 1 ☐ Yas 2 If Yas, Giva 1 ☐ Never Married 2 Married 2 No 1 ☐ Yas 2 ☐ No Spacify: Specify: White 3 ☐ Widowad 4 ☐ Divorced 16e. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry College (1-4or 5+) Elamantary/Secondary (0-12) Executive, Owner Automobile 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Frank Henderson Closs Jr. Alice Halsey 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 951 Shadewater Way Annapolis, Md. 21401 Elizabeth Closs (Wife) 20b. Place of Disposition (Nama of camatery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 X Crametion 3 ☐ Ramovel from Stata 2/18/99 Ft. Lincoln Crematory Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Spacify) 22. Nama end Addrass of Facility John M. Taylor Funeral Home Inc. 21. Signature of Funeral Sarvice Licens 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Betwaan Onset and Death Immediate Cause (Final disaasa or condition rasulting in daath) Dua to (or as a consequence of): ALDERSTROMS Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants resulting in daath) Lasf Dua to (or as a consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to complation of cause of daath? 24a. Was an autopsy 1 T Yas 217 No 1 □ Yas 2 □ No 28. Plece of Death (Check only one) Other: Nursing Homa 5 Rasidance 6 Other (Specify)

Physician /Medical Examiner

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The Funeral Directory filled in by

To the Hosp within 24 hor To the Fune completely fi

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or Attending Physician: after death. Director: After this certific

that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

The law requires

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

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Funeral

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Completed

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Hygiene.

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permit. Page Department of Important: If any injury or pace.

Baltimore, Maryland 21215-0020

Examiner Certification:

Physician/Medical þ Completed Be 2

25. Wes case referred to medical examiner? 1 Yas 2 No

27. Manner of Death 1. Natural 5 Panding 2 Accidant Invastigation

29b. Signature and title of certifie

(Check only

6 Could not ba 3 ☐ Suicide 4 Thomicida 29a. Cartifian

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Yaar)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

29c. License number

 Location (Straat and Number or Rural Routa Number, City or Town, State) Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date and place, and dua to tha causa(s) and mannar as stated.

| Medical Examinar: On the basis of axamination and/or investigation, in my opinion, daath occurred at the tima, data and place, and due to the causa(s)

29d. Date signed (Month, Day, Year)

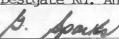
28d. Describe how injury occurred

30. Neme and eddress of erson who completed cause of daath (Item 23e) (Type, Print)

Stanley P. Watkins, Jr., M.D. 900 Bestgate Rd. Annapolis, Md. 21401

Registrar

31. Data filed (Month, Day, Year) FEB 1 9 1999 32. Registrer's Signatura Denev

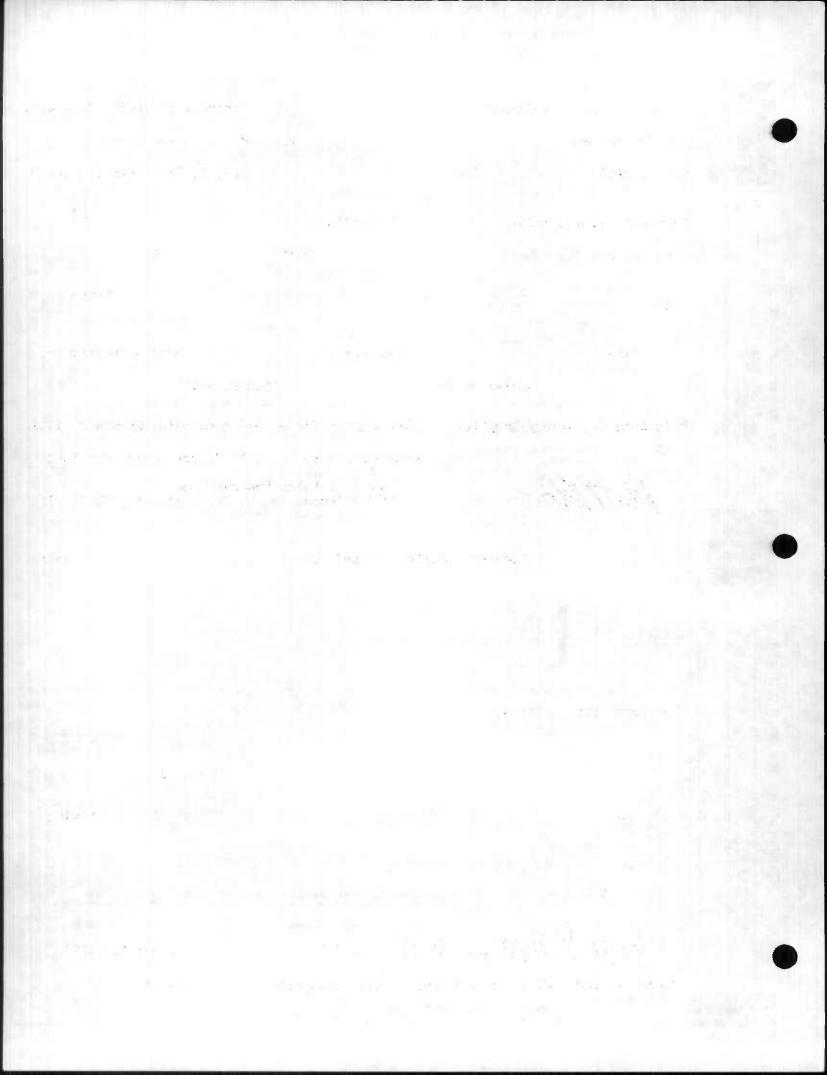


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State of Maryland / Department of Health and Mental Hygiene 9 07047

							Cert	ificat	e of	Death		Reg. No.	U	1041
			Decedent's Nama (First, Middle, Last)						2. Data of Death Month Day Year 3. Tima of				3. Tima of Death	
	Physicia /Medica		Helen Bernadine Cramer											7:50 A.M.
	Examine	An En	cility Nama (If not Institution	on, giva street and	number)			4b. City, Town, or Location of Daath 4c. County of					of Death	
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	Funeral Director	057	ial Security Number -12-9148 Residence of Decadant	6. Sax 1 □ M 2X	7. Aga F 10	(In yrs. last b	Yrs.	Months	Days	If Undar 24 H				placa (Stata or Foreign ington, DC
	dand dand	10a. S		1		10c. City, To	wn or Loca	ation					1	0d. Insida City Limits
	Mary	Mar	yland Anne	Arundel			An	napo	lis					Yas 2□No
	or 28	10e. S	Street and Number					101. Zip				10g. Citizen of \	What Cour	ntry?
	th wil	258	5 Golfers Ri	dge Road						21401		A		
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Ba	Department any ir		1/1/2011/1	Who -			Ge	orge	P.	Kalas F	uneral I	Home		
		238.	2973 Solomons Island Rd. Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										er, M	Approximata
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	To the Hospital or Attending Physician: The law within 24 hours aftar death. To the Funeral Director: After this cartificate has b completaly filled in by tha funeral director, page 2 s	29a. 0	Certifiar 1 Cartifyi Check only 2 Medical	Examinar: On th	a basis of a	examination a	ga, daath o and/or inva	occurred	at tha ti	ma, data and pia opinion, daeth oc	ce, and dua to the	ne ceuse(s) and m a, data and place,	annar as s and dua to	stated. tha causa(s)
	o the		one) and mannar stated. 29b. Signature and title of certifier 29c. Licansa number							sa number		29d. Data signe	ed (Month,	Day, Year)
	F 5 F 0		PATAR KAMPO - M					Г	11624	5/1		February 16, 1999		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							repruary	10,	1999			
			ter R. Graze			Bestga			Ant	napolis,	Maryla	nd 21/01		
	State	21 D	ata filed (Month, Day, Year) 3:		's Signature	4	Jau		_	THE ATOL	7 7 7 T		
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	H	5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday) If Undar 1 Yaar			1 Yaar	La P1		Char				
Funeral Director		577-72-5804 Usual Residence of Decedant	1 <u>⊠</u> M 2□				Days	Hours M	Irs. 8. Data of E (Month, I Sept.	Day, Year) 28,195	9. Birthpiaca (Stata Country) 28,1953 Wash.,		D.C.	
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Z sh and	-	19e. Informant's Name/Reletionsi			7_01	19b. Mai	ling Address	(Street	end Number or	Rurel Route Num	ber, City or Town,	Stete, Zip	Code)	
nore, N ages 1 and at of Health of of Health of other tr		Patricia Ann	Dozie	r/wi	fe	Nan	jemo	y, N	daryla	nd 206	ure/Route Number, City or Town, State, Zip Code) Road 20662			
		20e. Method of Disposition 1 ☑ Burial 2 ☐ Crametion		rom Stata	C	ametery, cri	emetory or o	ther plac	•	Dete	20c. Location			
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Physician /Medicai		Immediate Cause (Fine)	Gra	ind M	íal :	seizu	ıres	ass	ociate	d with			Onsat and E	Death
Examiner		Immediate Cause (Fine) disease or condition resulting in deeth)	e. hyp	ogly	cem	ia						- 1		
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Division of Vital Records, tor Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homloide	ned 200. F	uilding, etc	c. (Specify	e N. Ea	street, factor	y, office		28f. Location City or T Washin	(Street end Numb own, Stete) gton, D.C	per or Rura	il Route Num	ber,
Division or Attending Ph within 24 hours after death. To the Fureral Director: After thi compietely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical 8	g Physician: To Examinar: On ti	the best of	ot my knov exeminet	wledge, dee	th occurred	et the tin	ne, dete end ple pinion, deeth o	ace, end due to the	e ceuse(s) end me e, dete end pieca,	enner es s end due to	teted. the cause(s	;)
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		Melia	wi -	Tuy	nen	~ ,	0	D-50	0883		Februar	гу О	3,199	9
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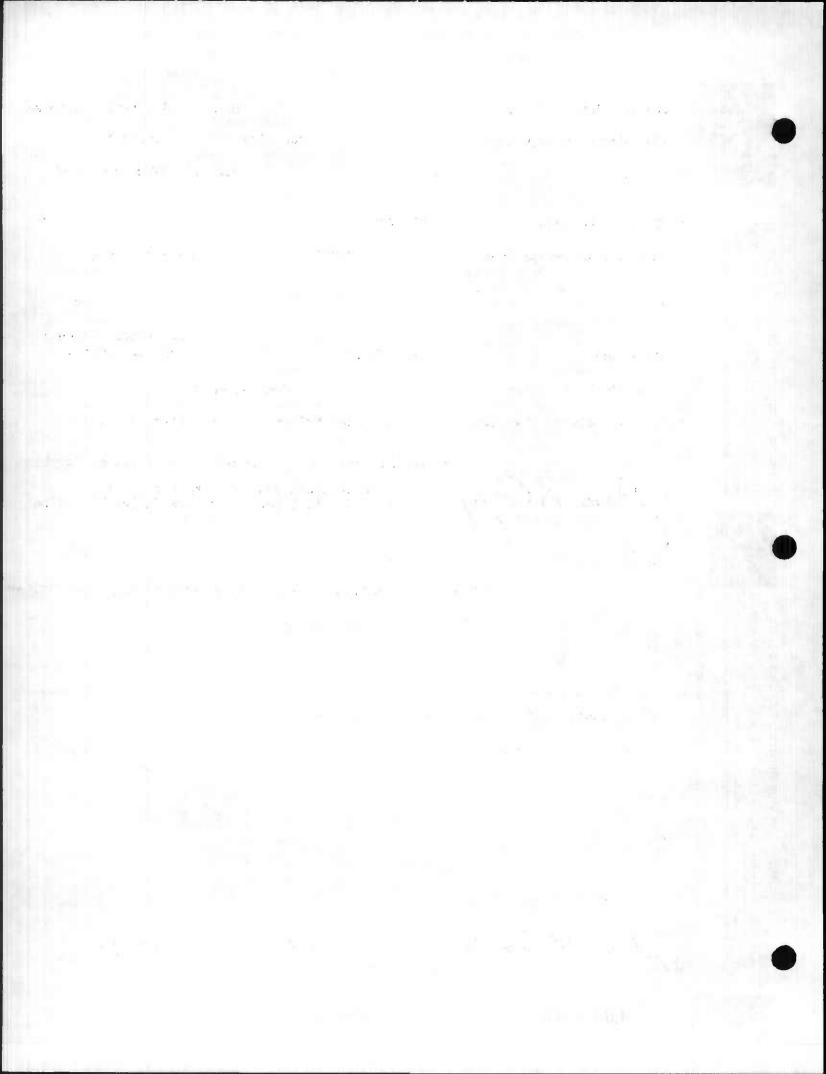
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3 Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** Feb. 1999 12:45 AM James Edward Dotson, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) **Examiner** Carroll 1410 Wooded Bridge Lane Mt. Airy If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer)
June 27, 1905 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthpiace (Stete or Foreign **Funeral** 125M 2□ F Deys Maryland 93 Yrs. 218-05-0606 Director Usuel Residence of Decedent deeth with the Merylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits triban "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Carroll Mt. Airv 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1410 Wooded Bridge Lane 21771 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bieck, White, etc. 11. Maritel Status filed within 72 hours efter (Hygiene. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☒ No Specify: þ Black 3₺ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry E. Stewart Mitchell Elementary/Secondary (0-12) College (1-4or 5+) Asphalt Company Truck Driver 6th grade 17. Fether'a Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fit ment of Health end Mentel Hant: If item 27 is marked oth jury or other traumatic even Emma Gardner Isaac Zachary Dotson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 1410 Wooded Bridge Lane Mt. Airy, MD 21771 Gloria A. Dotson Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20e Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State permit. Page Department of Important: If any injury or pace. 2/20/99 4 Donetien 5 ☐ Other (Specify) Woodville Cemetery Unionville, Maryland 21. Signature of Aunerei Service Licensee 22. Name end Address of Fecility Burrier-Queen Funeral Directors, P.A. ama 1212 W. Old Liberty Road Winfield, MD 21784 Approximate Intervel Between Onset end Death int. Enter the disease, or complications the cause of the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, lock or heart feiture. List only one cause of machine. **Physician** DAGS Imm-diate C se (Finel dise ndition resulting in deeth) /Medical SEPSIS **Examiner** Examiner IN PECTIONS MONTHS YEARS Due to (or es e consequence of): that the deeth certificete be executed physician end s the buriel-trans Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, PROSTATIC DISEASE Physician/Medical Due to (or es e consequence of) ettending USB Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à BED CONFINED þ 24b. Were autopsy findings eveilebie prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed JOINT DISEASE certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours efter deeth. 25. Wes case referred to medicel examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. fnjury et Work? 28d. Describe how Injury occurred Certification: 27. Menner of Deeth After 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident filled in by the f 28f. Locetion (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 D Homicide To the Hospital within 24 hours e To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature D26 499 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) P.O. Box 210, Mt. Airy, MD 21771 Ronald Miller 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture FEB 1 9 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mer

ntal Hygiene	0	9		7	0	5	0
Reg. No.	2	J	U	-1	U	V	U

			Ce	rtificate of	Death		Reg. No.	01000
	1. Decedant's Nama (First, Middle,	Last)				2. Data of Da		3. Tima of Death
Physician	PAHLINE RRING	LE DIEFFENBAC	CH			FEBRUA.	Dey 2/ 19	Year 0445
/Medical	4n English Name //f not institution		-		4b. City, Town, or I	Location of Death	4c. County	
. Examiner	Union Hospital		7		Filtran		Coo	2.1
			s. last birthday	If Under 1 Yaar	Elkton If Undar 24 Hrs.	8. Data of Bir	Cec	
Funeral Director	195-05-3402	1□M 2ਊF 8		Months Days	Hours Min.	8. Data of Bir (Month, Da	y, Year)	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residance of Decadant	4, 1915	rennsylvania					
Mo M	10a. Stata 10b. County	10c. C	City, Town or Lo	ocation				10d. Inslda City Limits
Wery fe sh	Manual and Garage	: 1				1 ☐ Yas 2 ☒ No		
vith the Mer or 28a-f si be notthed	Maryland Cec:		NOIL	h East			10g. Citizen of W	/het Country?
with on a								
e 23	44 Harry's Lane	12. Was Decedant Evar in	116 12	Was Decedest of	901 Hispenic Orlgln? (S	nacihi Vac or No		States - American Indian,
Pr de marie	11. Marital Status	Armed Forcas?	0,3.	If Yas, specify Cub	oan, Maxican, Puert	o Rican, atc.)		k, White, etc.
s aft	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva		1 ☐ Yes 2 🖾 No	Specify:		Specify	White
2 should be filed within 72 hours after deeth with the Meryland end Mentel Hygiene. Is marked other than "natural", or items 23e or 28e-f show summit event, the Medical Examinet must be notified at To Be Completed by Funeral Director	3 Vidowed 4 Divolced	Yaar or Dates:	10- D	4			10h Vind of Bu	-i
thin 72 hours aff a. "natural", or Medical Exam	15. Dacedent's (Specify only highest		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Bu	siness/industry
A Paritini	Elamantary/Secondary (0-12)	Collaga (1-4or 5+)			10)			
Sor the	12		Hom	emaker	T 40 14 11 4 11	(F) - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 -	Her Ow	
H of H	17. Fathar's Neme (First, Middle, Li	ist)			18. Mothar's Nar	ne (First, Middle,	Maiden Sumam	9)
Wend in Mend i	Joseph Bringle				Julia K	asper		
Maryland 2 should be file th end Mentel Hy 7 is marked oth traumatic event	19a. Informant's Name/Ralationshi	p (Type, Print)	19b. Mail	ing Addrass (Stree	t and Number or Ru	iral Route Numb	er, City or Town,	Stete, Zip Code)
alth alth	Harry A. Dieffer	nbach, Jr./Spou	ise 44	Harry's	Lane, No	rth East	. MD 2	1901
of Health of Hem 27 l	Harry A. Dieffer		Placa of Disp	osition (Name of	ice)	Data		
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Daltimore, Maryland Z1Z15-00Z0 bemit. Pages 1 and 2 should be filed within 72 hours after deeth with the Merylen Department of Health end Mentel thygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show mortant: or other traumatic event, the Medical Examiner must be notified at ance. To Be Completed by Funeral Director	21. Signature of Funeral Service Li						Pennsy	Ivania
Dentit. Departminimporta	110201	// //	C	rouch Fur	ass of Facility neral Hom	e		
	Marco O.	now	1	27 South	Main Str	eet, Nor	rth East	
	23a. Part1. Entar tha disaasa, or c shock, or haart failura. List or	omplications that causad the de nly ona ceusa on aach lina.	eth. Do not en	iter the mode of dy	ing, such as cardia	or raspiretory e	rrast,	Approximete Interval Batwaan Onset and Deeth
Physician								Oriset and Deeth
/Medical Examiner	Immediata Causa (Final disaasa or condition		Hours					
	rasulting in death)	Due to	(or as a conse	quanca of):				Years
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O. BOX 68 fou, le death cartificate be assecuted the attending physicien and hed for use as the bunal-transit vstclan/Medical Examiner	Saquantially list conditions,	Dua to	(or as e conse	quanca of):	Furtion further			
len e axe	Saquantially list conditions, if eny, leading to immediate cause. Entar Underlying Ceuse (Disease or Injury		perten					Years
DS/DU, lificate be ax g physicien as the burial-	that initiated avents resulting in death) Lest		or as e consa					
artifice ding pt	Todaking wir dodakiny book							
ath carl attandin for use		d						
death c	Part II. Other significant condition	contributing to death but not ra	asulting in tha	undarlying causa g	iven in Part I.	23b. Dld	tobacco una cor	tributa to the cause of death'
. = >9 =						10	Yes 2 No	3 Probably 4 Unknow
S, T as thet as thet be detabled by Dy								
requires requires hould be						24a. Was	en autopsy	24b. Were eutopsy findings evalleble prior to
v require been si should						pend	med?	completion of cause of deeth?
D & S C							_/	
Coata Coata						10	Yas 2 No	1 ☐ Yes 2 ☐ No
Physician: The law this certificate has trail director, page 2 strail director, page 3 strail director, page 3 strail director, page 4 strail director, page 5 strail director, page 5 strail director, page 6 strail director, page 6 strail director, page 6 strail director, page 7 strail director		11	-			ath (Check only	one)	
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n g P ge ther ther ther ther there and the second the s	27. Manny of Deeth	28a. Data of Injury (Month, Day Year)	28b. Time o	of 28c. Inju	iry at ork?	28d. Describe	how injury occurr	ed
DIVISION I or Attending after death. Director: After Jin by the funa	2 Accident Investiga			M 1]Yas 2□No			
or Attendi after death. Director: A In by the ft	3 Suicide 6 Could no 4 Homicide datamin		homa, farm, st	treet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural Route Number,
DIVISION C ball or Attending P is after death. al Director: After t ed in by the funara Certification:								
hour hour ly fill ly fill ly fill ly		Physician: To the best of my ki						
n 24 hound	one)	caminer: On the basis of axaminend manner steted.	nation and/or in	ivastigation, in my	opinion, deeth occi	irred at tha tima,	date end place,	and due to the cause(s)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completaly filled in by the funeral director, page Medical Certification: To Be Com					sa number			d (Month, Dey, Year)
) Mit	MD		Doc	47711		Februa	57 21, 1997
	30. Nama end eddrass of person w	no complated cause of death /li-	em 23e) /Turs	Print)				, ,
10	David Gar-El	3 Marillan	Averu	Nacel	East	Marul	und	1001
-01-1	24 Date filed (Month Day Vees)	32. Registrar'a Sig	,	1-017		1 001 1		
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DHMH 16 Rev 6/95

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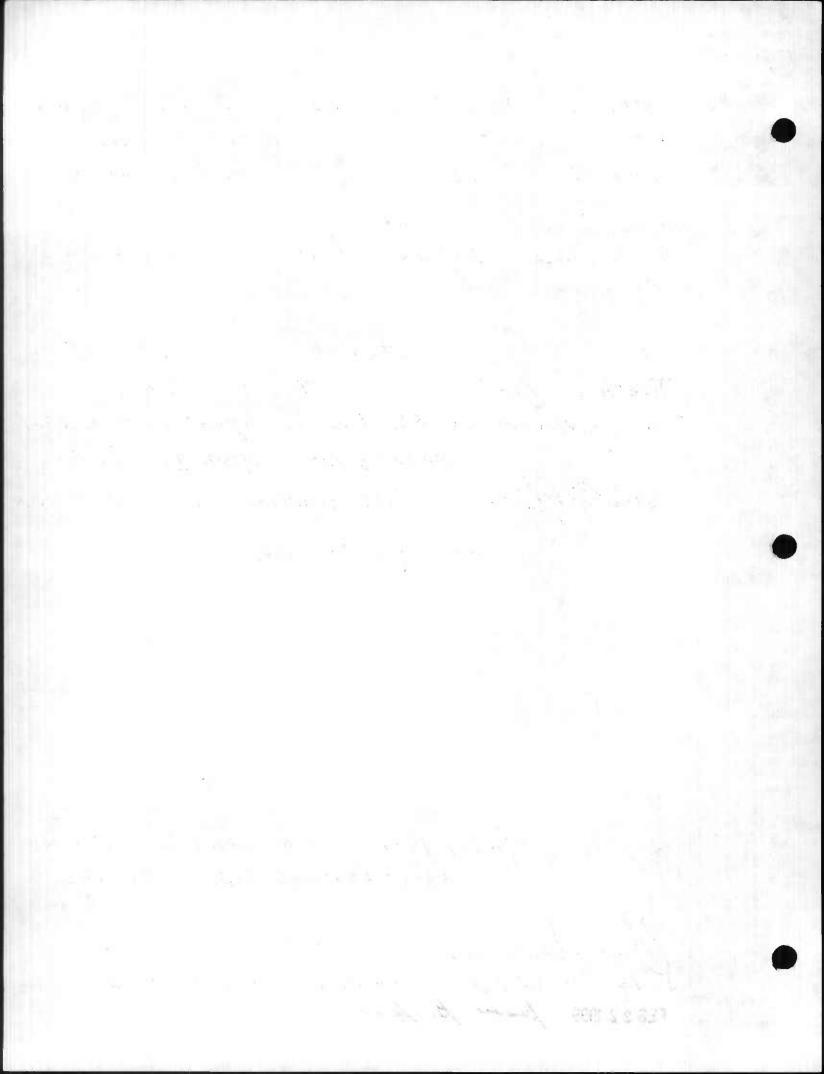
WRC 99-1004-015 KRYSTAL MARIE DONLON

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State of Maryland / Department of Health and Mental Hygiene 9 0 7 0 5 1

	ON			Certificate of I	Death	Reg.	No.	1001									
	Physician · /Medica	n	1. Decedent's Name (First, Middle, Last) KRYSTLE MARIE	DONLOR	V 1	Date of Death Month FEB. 20,	Day Year	3. Time of Death 3:48 PM.									
	Examine	_	4a Facility Name (If not institution, give street end number) AMTRACK LINE MILE 51.02	4	b. City, Town, or Locati ELKTO		4c. County of Death										
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lest bit 0/2-66-2874 1 M 2 F	irthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Dey, Yea		pplace (State or Foreign intry)									
	Maryland -f ehow		Usuat Residence of Decedent 10a. State 10b. County 10c. City, Tow	wn or Location				10d. inside City Limits 1 ☑ Yes 2 ☐ No									
		eral Director		e l	100. Street and Number 421 W. Pulaski HighWA	10f. Zip Code 2/9/	21		Citizen of What Cou								
020	ours after dee	2	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Ispanic Origin? (Specify in, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Amer Btack, White Specify: WH										
21215-0020	within 72 hours lens. than *naturel', Tre Medical Ex	Completed	(Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+)	a. Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired 5 Tudew 1	ation during most of working	16b	Stude	,									
			8 17. Father's Name (First, Middle, Last)	STUCENT	18. Mother's Name (F	irst, Middle, Maic		<i>3.0</i> /									
Maryland	Aantei Aantei rked o	o ne	Joseph E. DONLON		TRUDY	m. F	REAMS										
ary	and No.			b. Mailing Address (Street	and Number or Rulel R	oute Number, Ci	ity or Town, Stete, Z	ip Code)									
-	Pages 1 end sent of Health nt: If item 27 is yor other tr				TRUCHM. DONLOW - MOTHER 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	of Disposition (Neme of ery, cremetory or other place	ASKI HIG	hula / - 20c 23/99 11	ELKton Location - City or T	MD, 21921 Fown, State							
Baltimore	permit. Pa Departmen important: eny inlury once.		21. Signature of Funerat Service Lipensee	22. Name and Address	ss of Facility Veral Home	259€.	MAN St	Elkton Ma									
	33 V		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart fellure. List only one ceuse on each line.	not enter the mode of dyin	g, such as cardiac or re	spiratory arrest,		Approximate Interval Between									
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a	a consequence of):	jures			Onsel and Death									
68760,						ilcal Examiner		edical Examine				if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury c	consequenca of):				
	5 0 6	/wex	d														
P.O. Box	requiras thet the death cert seen signed by the attendin should be datached for usa	hysician	hysician	hysician	hysician/	Physician/M	hysician	hysician	hysician	hysician	Part It. Other significant conditions contributing to death but not resulting	en in Part I.	23b. Did tobac	10	to the cause of death?		
Vital Records,	w requires the been signed should be d	Completed by				24a. Wes an au performed	1?	Were autopsy findings avaitable prior to completion of cause of deeth?									
Re	The law ate has the page 2 s	E O				Yes	2 No /	Yes 2□ No									
/ita	certificate	00	25. Was case referred to medical examiner?		26. Piece of Deeth (C	heck only one)		۸π									
of V	hys id	2	1 X Yes 2 No Hospitat: 1 □ Inpatient 2 □ ER/O	The state of the s	4 Nuising Home		e 6 KOther (Spec	AT SCENE									
Division	Attending P or death. ector: After I by the funan	Certification:	1 □ Natural 5 □ Pending 2 Accident investigation 3 □ Suicide 6 □ Could not be	711	Yes 20 No	blects Location (Stree	Injury occurred Inchy t and Number or Ru	train									
ō.	after Direction of In b	e La	4 Homicide determined building, etc. (Speedly)	DI GOAD TH		TRAK LIA	in Ales	7.02									
		Medical	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledg 2☒ Medical Examiner: On the basis of examination er and manner stated.		ne, date end placa, and	due to the cause											
	To the To the complete complet	Ξ	29b. Signature and title of certifier	29c. License			Date signed (Monti										
			(Jaintole M)		O.C.M.E.	F'E	EB. 21, 19	199									
	1			(Type, Print) Penn Street	, Baltimor	e, Maryl	and 21201										
	State Registra		FEB 2 2 1999 Security 32. Registrar's Signature	Sporks													

DHMH 16 Rev 6/95



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIFIC	CATE OF	DEATH	REG. N	0.				
	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE OF DEATH			3. TIME OF DEATH		
	Andrew Henry Dure	en, Jr.					Lebrusy 15, 1999			22,35 M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. lest I	hiethelm i	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	15) /		LACE (State or Foreign		
		1 2 M 2 F			WONTHS DAYS	HOURS MIN	(Month, Day, Year)	1010	Country)			
	220-52-4283		49				ember 15,			yland		
	9a. FACILITY NAME (If not institution, give :	street and number)			9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUN	TY OF DE	АТН		
8	108 Beech Drive				Elk	ton		Cec	il			
DIRECTOR	RESIDENCE OF DECEDENT											
2	10e. STATE 10b. COUNT	Υ		10c. CITY,	TOWN OR LOC	ATION				10d. INSIDE CITY LIMITS?		
ā	Maryland Cecil	i.		Ell	cton] .	1 YES 2 X NO		
7	10e. STREET AND NUMBER				1	of. ZIP CODE		10g. CITIZ	ZEN OF WI	IAT COUNTRY?		
8	108 Beech Drive				1	21921		Un	ited	States		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARM	FD	13. WAS DE		NIC ORIGIN? (Specify Y					
	1 Nover Married 2 Married	FORCES? 1 X Y	ES 2 NO		If yes, s	pecify Cuben, Mexico	en, Puerto Rican, etc.)			- American Indian, White, etc.		
BY	3 Widowed 4 Divorced	1970-1973	R DATES		1 U YE	S 2 NO Specif	y .	i	Specify	Black		
	15. DECEDENT'S EDU		16a DECI	EDENT'S II	ISUAL OCCUPAT	ZON	16b. KIND OF B	HOINEGO (IND)		Stack		
	(Specify only highest grade		(Give	kind of wo	ork done during n retired.)	nost of working	100. KIND OF B	OSINESS/IND	DSTHY			
	Elementary/Secondary (0-12)	College (1-4 or 5 +)					Dadima					
M	10		Tra	ckmaı	n.		Railroa					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middle, Maide	n Surname)				
BE	Andrew Henry Dure	en, Sr.				Zynith	Mame Hamm	nond				
	19a, INFORMANT'S NAME (Type/Print)		19b.	MAILING /	ADDRESS (Street	and Number or Rural	Route Number, City or To	wn, State, Zip	Code)			
2	Linda D. Duren/	Wife	10	8 Bee	ech Dri	ve. Elkte	on, Maryla	and 21	921			
	20a. METHOD OF DISPOSITION			_						Photo		
1	1 XBuriel 2 Cremetion 3 Removal from State Commetery, Cremetory, or other place) February 19, 1999											
	4 Donellon 5 Other (Specify) Trinity A. U.M.P. Church Cemetery Zion, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	21. SIGNAL OF PONEME SERVICE E	Hicks Home for Funerals, P.A.										
	Darra d.	S. Head	(4)				ton Street	-		ID 21921		
	23. PART i. Enter the diseases, or	complications that cau	sed the dea	th. Do no						Approximate		
		List only ona cause o				7		, manage of		Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death) 8 / / Carrer a. Bi// Carry Carrer											
	resulting in death) a. 11/1 ary Cancer 7 mo											
	DUE TO (OR AS A CONSEQUENCE OF):											
ž	Sequentially list conditions, Due to (or as a consequence of):											
CERTIFICATION	If any, leading to immediate	DUE TO (OR A	AS A CONSEOL	JENCE OF)	:							
2	ceuse. Enter UNDERLYING CAUSE (Disease or injury	c										
쁘	that initiated events	DUE TO (OR A	AS A CONSEOL	JENCE OF)	1.							
8	reaulting in death) LAST	d										
	PART II. Other significent conditio	ne contributing to deal	th hut not re-	eultino le	the underly	na anusa ahuan la	Boot I Dec 1980	N ALCTONON	1 045	WEST AUTOBOX ENDINGS		
AL	PART II. Other significant condition	is contributing to deal	in but not re	suiting if	i ine underiyi	ng cause given in	PERF	N AUTOPSY ORMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
MEDICAL							1 TYES	2 NO		COMPLETION OF CAUSE OF DEATH?		
M										1 YES 2 NO		
÷	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEAT	H YES	NO I	UNCERTAL	N□					
M	25. WAS CASE REFERRED TO MEDICAL	T	26. PLACE	OF DEATH	H (Check only on	9)						
5	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/0	Outputlant 2 [OTHER:		- A - T - AH - 10 - H - 1					
PHYSICIAN:	27. MANNER OF DEATH	26a. DATE OF INJU		28b. TIME		JURY AT	6 Other (Specify) 28d. DESCRIBE HOV	IN HIEV OC	CURED			
	1 Natural 5 Pending	(Month, Day, Ye		INJU	JRY V	ORK?	200. DESCRIBE HOT	I INJUNT OCC	UNED			
BY	2 Accident Investigation	2 Accident Investigation 1 TES 2 NO										
2 Suicide 28, LOCATION (Street and N								it and Number te)	or Rural Ro	oute Number,		
	4 Homicide determined											
٦	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my k	nowledge, deal	th occurred	d at the time, da	te and place, and du	to the cause(a) and m	enner as stat	ed.			
M	one)									and manner as stated.		
O												
BE	296. SIGNATURE AND TITLE OF CERTIFIE	IN D				29c. LICENSE NU	MBER	29d. DATI	E SIGNED	(Month, Day, Year)		
ဝို	181 Javies	, / ')	_			1 1 / 5	>14	1-2	-6. /	6,1999		
	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF	DEATH (ITEM	27) (Type,	Print)	,	./					
	17 - ar Ras, MI	VNA!	Vorth	41	Chos.	Deake.	Hospice	Elki	on.	MD		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S S	SIGNATURE		/	1	, ,		-			
	LED T (1999	Labergeron	D.	de	200 Kal							

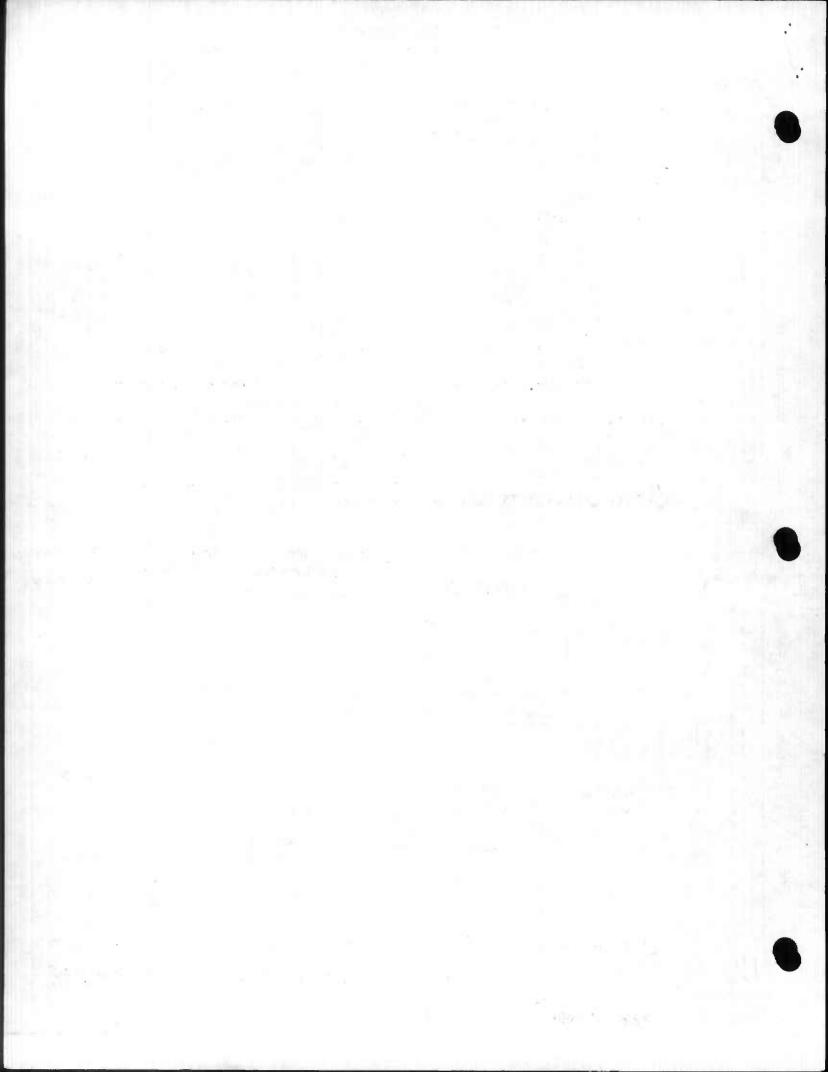
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneg Certificate of Death Amend Item 5, 2/22/99, bam 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 9:53 p.m. Frederick Henry Dierkes February 12, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XIX M 2 F 226-60-8953 Yrs 74 Director April 13,1924 Germany Usual Residence of Decedent worle 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10 Yes 2 No Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? P 9 540 Franklin Street 21903 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) naturel', or items 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Namied 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Two Years Elementary/Secondary (0-12) Machinist Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 1 and 2 should be Health and Mentel Friedrich Dierkes Elisabeth Schlinkmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health e (important: If item 27 is any injury or other trainings) Irmgard G. Dierkes (wife) 540 Franklin Street, Perryville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stele 20a. Method of Disposition Dete Pages 1 1 Burial 2 □ Cremation 3 □ Removel from Stete Immaculate Conception Cemetery 2/16/99 4 ☐ Donation 5 ☐ Other (Specify) Elkton, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens Lee A. Patterson & Son Funeral Home attersox Perryville, Maryland 21903-0188 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel a. END STAGE CHRONIC DASTRUCTINE
Due to (or as e consequence of): PULMONARY DISEASE disease or condition resulting in death) Examiner Examiner SEP515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 2 No Vitai Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Netural deeth. 1 Yes 2 No 2 ☐ Accident after deetl Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide 24 hours Funeral 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Funs completely t (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier non Sharing FEB. 13Th, 1999 D 31856 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. SIARMA MD 1814 BTEL AIR RD. EALSTON 21047 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Louks Registrar FEB 1 7 1999

DHMH 16 Rev 6/95

er 205,



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death ROTHU 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4 GILMER STREET ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 X F Months Yrs. 217-32-8655 66 JUNE 16,1932 MARYLAND Usual Residence of Decedent 10b Counts 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL ANNAPOLIS 1 X Yas 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 GILMER STREET 21401 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 0 HOMEMAKER HOME 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) JAMES BENSON FARRELL SARAH ELIZABETH TAYLOR 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) DIANE JOHNSON (DAUGHTER) 17 GILMER STREET ANNAPOLIS, MD. 21401 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02-15-99 OWENSVILLE, MD. CHRIST CHURCH CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Licenses JOHN M. TAYLOR FUNERAL HOME, INC 147 DUKE OF GLOUCESTER ST. ANNAPOLIS. MD. 2140 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Onsat and Death Kneumonia Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to hypertension. 24e. Wes an autopsy performed? completion of cause of death? NA 22 No 1 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Director

Funerai

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Completed

Funeral

Director

the Maryland

Pages 1 end 2 should be filed within 72 hours after death with the Marylan nent of Health and Mentel Hygiene. Intit if fem 27 is marked other than "natural", or items 23s or 28s-f show inty of other traumatic event, he Model Exertive Frust en potitied as iny or other traumatic event, he Model Exertive Frust en potitied as

Baltimore, Maryland 21215-0020

Examiner physician and is the bunel-transit Physician/Medicai 98 ettanding p signed by the þ

that the death certificate be executed

law requires

Division of Vital Records, P.O. Box 68760,

s cartificate hes b Hospital or Attending Physician: 24 hours efter death. Funeral Director: Aftar this cartific. funeral director

Completed

in by To the Hospital or within 24 hours eft To the Funeral Di completely filled in

Be Certification: To

Medicai

25. Was case referred to medical exeminer? 1 Yes ≥ No 27. Manner of Deeth

5 Pending 2 Accident 3 Suicide 6 Could not be determined

4 Homlcide 29a. Certifier

28e. Dete of Injury (Month, Day Year)

Investigation

28b. Time of

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifian

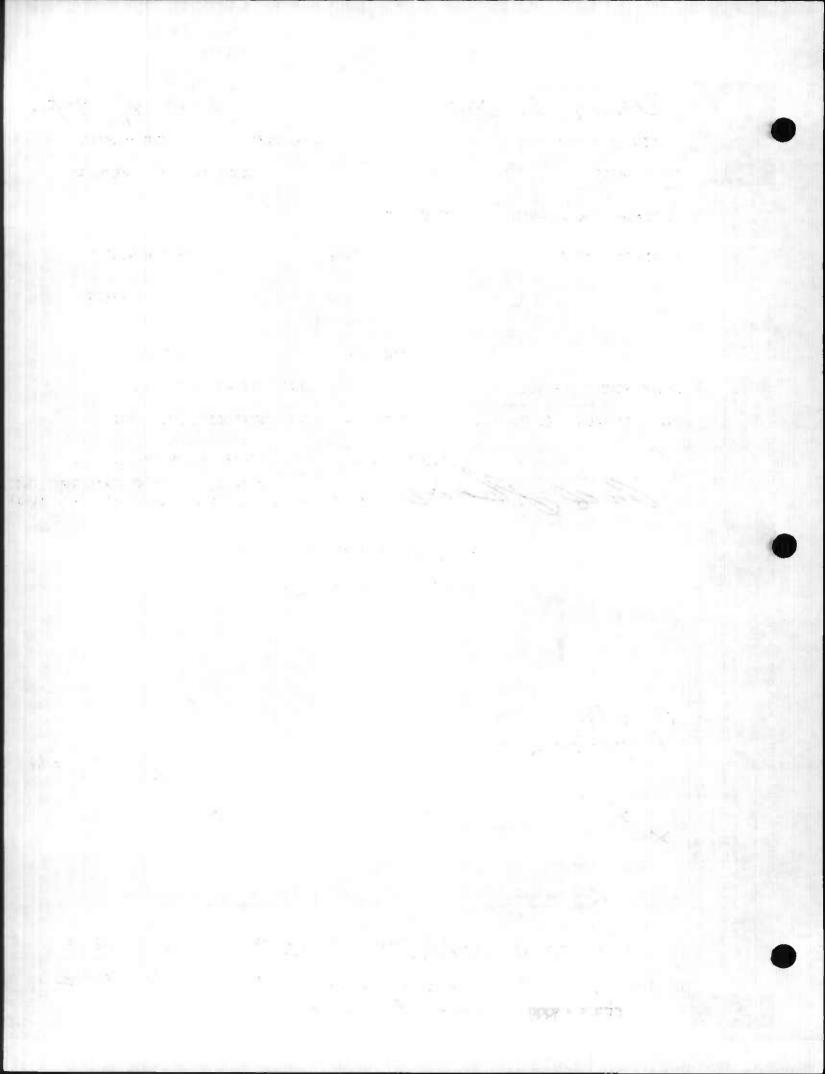
29c. Licansa number

28c. tnjury at Work?

29d. Data signed (Month, Day, Year)

Farm ROAD ARNOLD MD 21012

State Registrar 31. Date filed (Month, Day, Year) FEB 16



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 0 7 0 5 5

		1. Decedent's Neme (First, Middle, Last)		Certificate of		2 Date of De	Reg. No. eth		3. Time of Deeth			
Physic		Royal Dyal Jr.					Feb.	17 Dey 19	9 ^{gear}	4:55 AM			
/Medi Exami		4e. Fecility Neme (If not institution, give	street end number)		4b. City, Town, or Lo			of Deeth	1100 7111			
		Chesapeake Future	Care			Arnold		Anne	Arun	del			
Funeral Director		5. Social Security Number 257-46-8677 6. Se	X 7. A	ge (In yrs. lest bir 66	Mantha Dave		8. Dete of Bir (Month, De Jan. 1	th y, Year) 6.1933		ece (Stete or Foreig y) Fgia			
*		Usuel Residence of Decedent 10e. State 10b. County		10c. City, Tow				.,					
r 28a-f ahow a notified at	tor	Maryland Anne Aru	ndel	Arnolo					100	d. Inside City Limit 1 ☐ Yes 2 ☐ N			
or 28)irec	10e. Street end Number			10f. Zip Code			10g. Citizen of \	Whet Countr	y?			
23a	ai	813 Clifton Ave.			21012			United	States				
al', or items Examiner in	by Funeral Director	11. Maritel Status 1 Never Married 2 (A) (arried 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces Y Yes 2 If Yes, Give Year or Detes:	no 1952	13. Wes Decedent of If Yes, specify Cub		ecify Yes or No Rican, etc.)	- 14. Red Bled Specify	ck, White, et	tc.			
natural', dical Ex	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a.	Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire	petion during most of work	ina	16b. Kind of Br	usiness/Indu	istry			
han M	mpi	Elementery/Secondery (0-12)	College (1-4or	5+)									
other thai	ပိ	12 17. Fether's Neme (First, Middle, Last)			Security Offi		- APT - A B AT 1-31-			American Indien, White, etc. White ness/Industry Maryland ate, Zip Code)			
o d	To Be	Royal Dyal, Sr.				Lovey H		Meiden Sumen	10)				
la m		19e. Informent's Name/Relationship (T) Sue Ellen Dyal (W	rpe, Print) ife)		. Meiling Address (Street 13 Clifton A								
nt: If itsm 27		20e. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F	temovel from Stete	20b. Plece of cameter	Disposition (Name of y, cremetory or other ple rest Memo	rial 2	Dete /20/99		-				
Important: If i any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		~	22. Neme end Addre	ass of Eacility L	120/33	Annapo I	is, Ma	aryland			
Importan any injur		Bered	m. BC	Den		. 00							
ysician Medicai aminer		23a. Pent1. Enter the disease, or dempt shock, or heart failure. List only of the disease or condition resulting in death)	se cause on each	SN	cónsequence of):	ng, such es carriag (or respiretory e	1001,		nterval Between Onset end Deeth			
	ner		Puer	mon					1	week			
frans	E	Sequentially list conditions,)		consequence of):								
hysician end the burial-transit	Ē	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury							į				
O 8	Medicai Examiner	thet initiated events resulting in deeth) Lest		1									
ettendin for use	clan												
ached	/ Physic	Pert II. Other significant conditions con	deributing to death to	out not resulting in	the underlying cause gi	ven in Pert I.		Yes XNo					
s been signed is 2 should be det	Completed by Physician/	Varenter PITUTORY TU	mar.					en eutopsy med?	eveil	e autopsy findings leble prior to pletion of cause seth?			
ate has page 2	mo;						101	res 2000	10	Yes 2□ No			
is certificate director, pag	Be	25. Was case referred to medical exeminer?				26. Plece of Deetl	h (Check only o	ne)					
0 0	To	1 Yes 2 No	lospital: 1 ☐ Inpati	ent 2 ER/Ou	tpetient 3 DOA	her: Nursing Ho	me 5 Resi	dence 6 Oth	er (Specify)				
erai erai	Certification:	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident Investigation	28e. Date of Inj (Month, Da	ay Year) 28b. 1	ime of 28c. Injury Wo	ry et ork?] Yes 2 ☐ No	28d. Describe I	now injury occur	red				
r: Aft	ific	3 Suicide 6 Could not be determined	28e. Pleca of In building, e	jury - At home, fe tc. (Specify)	rm, street, fectory, office		28f. Location (: City or Tox	Street and Numb vn, State)	er or Rurel i	Route Number,			
Director: After the fundamental of the post of the fundamental of the	en	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office 28f. Location (Street and Number or Rurel Route Number)											
• Funeral Director: After letely filled in by the fun	edical Cert	29a. Certifier (Check only one) 1 Certifying Physical Example (Check only one)	sician: To the best ner: On the basis of end menner si	of examination en	, deeth occurred at the tid d/or Investigation, in my o	me, dete end pleca, opinion, death occurr	end due to the ed et the time,	cause(s) end me date end placa,	end due to t	ted. he cause(s)			
within 24 floors after bearin. To the Funeral Director: After completely filled in by the fun	Medical Cert	29b. Signeture end title of certifier	end menner s	of examination end	29c. Licens	opinion, death occurr	ed et the time,	cause(s) end me date end placa, 29d. Dete signe	end due to t	he cause(s)			
within 24 floats after loadin. To the Funeral Director. After th completely filled in by the funeral	Medical Cert	one) 2 Medical Exami	on the basis of end menner si	of examination enclated	29c. Licens	opinion, death occurr se number	ed et the time,	date end placa,	end due to to	he cause(s) ey, Yeer)			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth Month 12:35 PM **JOSEPH ALBERT** DROTTAR **FEBRUARY 25** 1999 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Berlin Nursing and Rehabilitation Center Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/12/23 9. Birthplece (State or Foreign Country) Maine 7. Age (In yrs. lest birthday) 10 M 2□ F Deys 006-16-9677 Yrs. 75 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Worcester Ocean City 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21842 USA 133 Clam Shell RD 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Married 2 Married 1 CKYes 2 No If Yes, Give Yeer or Dates: WW I 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Airplane Manufacturer Civil Engineer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Elizabeth Jacob Michael S, Drottar 19e. Informent's Neme/Relationship (Type, Pnint) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Clam Shell RD Ocean City, MD 21842 Agnes Drottar/ Wife 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Removel from State Cape Henlopen Crematory 2/26/99 Frankford, DE 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Facility rvice Licenses Burbage Funeral Home 108 William St. Berlin, MD 21811 ons that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, ause of mach line. Approximate Interval Between Onset end Deeth Immediete Cause (Finel diseese or condition resulting in death)

Physician /Medical Examiner

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ne any injury or other traumatic event, the Westernoons."

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

10e. State

MD

Funeral

Director

r than "natural", or Items 23s or 28s-f show the Wedical Examiner must be notified at

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

physician and s the burial-transit attending pl been signed by the s should be detached page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Ihal Initiated events		CUROTIC or es e consequence o		ASCULAK DO	32736		
thel initiated events resulting in deeth) Lest	Due to (or es e consequenca of	i):				
Pert II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	g cause given in Pert I.	23b. Did tobacco use c	ontribute to the cause of death?		
				24e. Wes en eutopsy performed?	24b. Were eutopsy findings aveileble prior to completion of cause of deeth?		
				1 □ Yes 2 No	1 □ Yes 2 No		
25. Was cese referred to medical examiner?			eath (Check only one)				
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpetient 3□ [Home 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Deeth 1 Naturel 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occu	rred		
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Special	nome, ferm, street, fectorify)	28f. Location (Street and Num City or Town, Stete)	ber or Rural Route Number,			
29a. Certifier (Check only one)	ysician: To the best of my known ther: On the basis of exeminating end menner stated.	owledge, death occurre etion end/or investigetion	d et the time, dete end plecon, in my opinion, deeth occ	e, end due to the ceuse(s) end m urred at the time, date and place	nenner as stated. , and due to the cause(s)		
29b. Signature and fille of certifier		. 2	9c. License number	29d Data sign	ed (Month Dev Veer)		

2/5/99

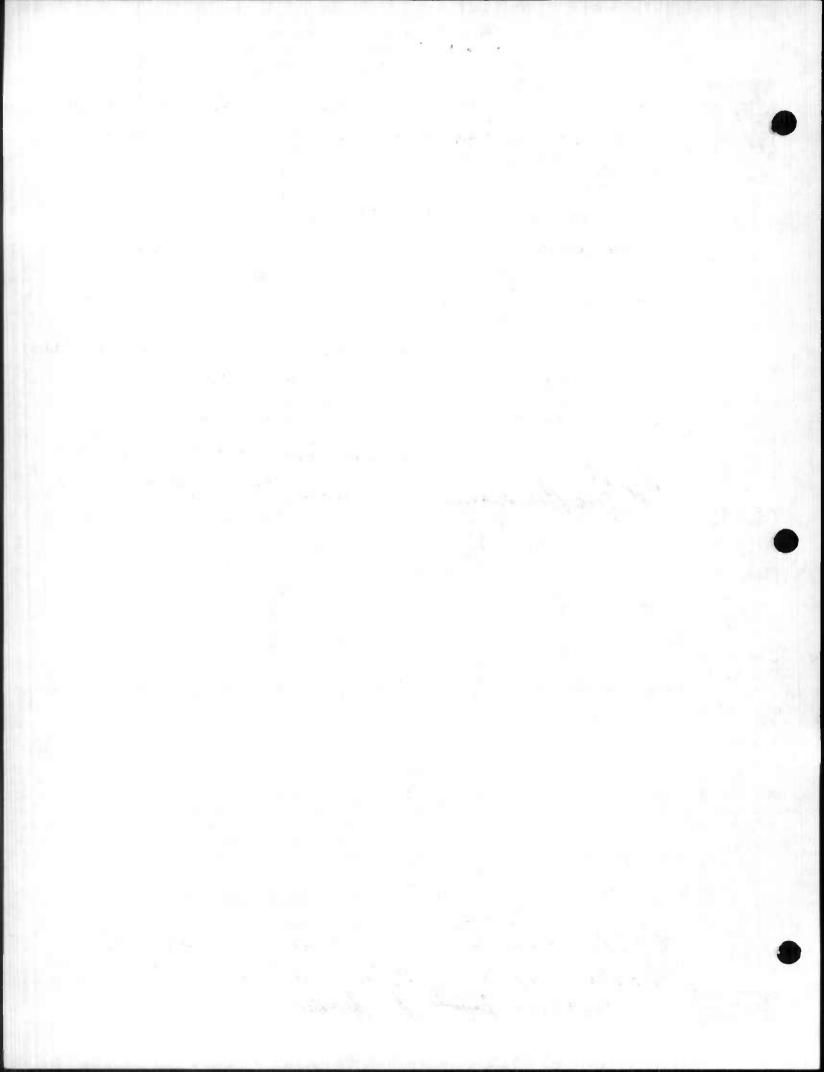
State Registrar 30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

32. Registrer's Signeture

714 Healthway

FEB 2 5 1999

31. Dete filed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieneg 9 0 7 0 5 7

				Certifica	te of	Death		Reg. No.	0700	, ,
	1. Decedent's Neme (First, Middla, L	ast)		177			2. Data of I	Deeth	3. Time	a of Deeth
Physician /Medical	Maryanna	Earp					Febru		1999 2	200
Examiner	4e Fecility Name (If not institution, g	iva street end number)				4b. City, Town	, or Location of Dec	eth 4c. County	of Deeth	
47	Union Hospital						ton	Ce	ecil	
Funeral Director	5. Social Sacurity Number 6. 1.80 14 7841	Sex 7. Ag 1 □ M 2√Ω F	ge (In yrs. lest bir 81	Yrs. If Und Months	er 1 Year Days		Min. (Month, I	Birth Dey, <i>Year</i>) 4, 1917	9. Birthplece (Stell Country) Pennsylva	
2	Usuel Residence of Decedent		10- Oit Tour						and traid	04.11.4
with the Marylend a or 28a-f show be notified at	Maryland Cecil		10c. City, Tow Ea:	rlevill	е					e City Limits es 2 No
Unter death with the Marriages 23a or 23e-1s.	10e. Street and Number 4731 Augustine	Herman Hio	hway	10f. 2	ip Code	21919		10g. Citizen of \Unite	What Country?	
13-0020 172 hours efter deeth with the Manylen 172 hours efter deeth with the Manylen fratural; or items 23a or 28a-f show arcal Examines must be notified at lefted by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forces? 1 Yes 20 If Yes, Give Yeer or Detes:	Evar in U,S.	13. Wes Dec If Yes, sp			? (Specify Yas or Puerto Ricen, etc.)	No- 14. Rac Blac Specify	ce - American Indian ck, White, atc. cy: White	i.
72 hours "natural",	15. Decedent's I		16e.	Decedent's Us	uel Occu	pation during most of	f working	16b. Kind of B	usiness/Industry	
Mary jaring A 12.15-0020 d 2 should be filed within 72 hours of this and Markel Hygiens file marked other than "natural", or traumatic avent, the Marical Exam To Be Completed by 8	(Specify only highest g Elementery/Secondary (0-12) 12	College (1-4or	5+)	life. DO NOT	use retire	ed)	WORKING	In her	own home	
Be C	17. Father's Name (First, Middle, Las	t)				18. Mothar's	Neme (First, Midd	le, Meiden Sumen	пе)	
Mentel Me	unknown						unknown			
Shou M M M M M M M M	19e. Informent's Name/Reletionship	(Type, Print)	196	. Mailing Addre	ss (Stree	t end Number o	or Rurel Route Num	ber, City or Town,	, State, Zip Code)	
M 2 Dod 2 Dod 2 List at the street	Irene Paulovitz		an Highwa	av. Earle	eville, M	D 2191				
Daltimore, Maryland Z 1Z permit. Peges 1 and 2 should be filed within Department of Health and Mandel Hygene. Important: It flem Z is marked other than any injury or other traumatic avant, me than the mones. To Be Compl	20e. Method of Disposition 1 Survival 2 Cremetion 3		20b. Place o cemate.	f Disposition (N ry, cremetory or	eme of other pla	ace)	Dete	20c. Location -	- City or Town, Stete	
. Pe tmen tant: jury	4 ☐ Donation 5 ☐ Other (Spec		Pomf	ret Man		emetery	2/23/9	9 Sunbu	ry, PA	
Physician /Medical Examiner	23e. Pert1. Entar tha disease, or conshock, or heert fellure. List only immediate Ceuse (Finel disease or condition resulting in deeth)	y one ceuse on eech l	yo Lara	lial =	Ln			errest,		Between nd Deeth
eath certificate be executed ether certificate be executed for use as the buriel-trensit clan/Medical Examiner	Sequentially list conditions, if any, leeding to immadiate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting In deeth) Last	c	Due to (or es a	consequence o	i):					
death death ed for u	Pert II. Other algnificant conditiona	contributing to death b	out not resulting l	n the underlying	ceuse g	iven In Pert I.	23b. DI	d tobacco usa co	ontribute to the cau	se of death
es that the death cer gned by the ettendin be deteched for use by Physician/N	Alz	hermon					1[3 □ Probably 4	I 🗆 Unknow	
v requir been s should				24e. Wes en autopsy performed? 24b. Were eu eveileble completi of deeth			osy findings ior to of cause			
ysicien: The levysicien: The levdirector, page 2			10	Yes 2 No	1 ☐ Yes	219 No				
clan clan	25. Wes case referred to medical axaminer?	Hospital:	-		0	hor	Deeth (Check onl			
Physician: rthis certific ral director,	1 Yes 2 No	1 L Inpati		-	JUA		ing Home 5 Re	41111		
Attanding F ortor: After by the funer iffication:	1 Neturel 5 ☐ Pending 2 ☐ Accident Investigeti		y Year)	Time of njury M	28c. Inju Wo	ork?]Yes 2□No		e how injury occur		
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director Medical Certification: To Medical Certification: To	3 ☐ Suicide 6 ☐ Could not determine	28e. Plece of In	jury - At home, fa ic. (Specify)	irm, street, facto	ory, office		28f. Location City or 7	(Street and Numi Town, State)	ber or Rural Route N	lumber,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hyelclan: To the best minar: On the basis o end menner st	examinetion en	e, deeth occurre d/or investigetion	d at the t	ime, date end p opinion, deeth	pleca, end due to the concourred et the time	ne ceuse(s) end m e, dete end plece,	enner es stated. and due to the ceus	se(s)
Vithin Vithin Co the comp	29b. Signatura and title of certifier	_	- 141	2	9c. Lican	sa number		29d. Data signe	ed (Month, Dey, Yea	ir)
->-		MD	4-1		Doo	47711		Februa	ry 21,1°	999
0	30. Name end eddress of person who	completed ceuse of a	A	(Type, Print)	orth	Enit	Maryla	سل کا	901	
State	31. Dete filed (Month, Dey, Year)	32. Registr	ar's Signeture	10-	1		-			

DHMH 16 Rav 6/95

SEES TO THE PROPERTY OF THE PARTY. Marine in the second to the " Brown or a second of the sec

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth Month Elizabeth Esposito 00:06am rebruary 21, 1999 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Dorchester Dorchester General Hospital Cambridge | If Under 1 Yeer | If Under 24 Hrs. | 8. Data of Birth (Months Days Hours Min. | July 20, 1919 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthpleca (Stata or Foreign 1 M XXF 79 Yrs. Maryland 217-10-7848 Usual Rasidanca of Dacadant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland Dorchester Taylors Island 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4255 Robinson Neck Road 21669 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas Y W No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Rece - Amaricen Indian, Bieck, White, etc. 1 Naver Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowad 4 Divorcad 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highest grade complated) Elamantary/Sacondary (0-12) College (1-4or 5+) 11 Homeowner Own Home 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Eli Wilson Agnes Isabel Winebrenner 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) John L. Sewell Personal Rep. P.O. Box 44 Taylors Island, Maryland 21669 20b. Pleca of Disposition (Nama of camatary, crematory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata Salisbury Crematory 2/22/99 4 ☐ Donation 5 ☐ Othar (Specify) Salisbury, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Fecility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwean Congellive Heart-failure
Dua to (or es e consaquence of): Immediata Causa (Finel 12 1 YS disaasa or condition rasulting In daath) Aspira n'a Sequentially list conditions, if any, laading to immadiate ceusa. Enter Underlying Cause (Disaasa or Injury that Initieted avants rasulting in daath) Last Dua to (or es e consequance of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy parformed? complation of cause of death? 1 ☐ Yas 2 Stato 1 Yes 20-No 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □ patient 2 □ ER/Outpatient 3 □ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred

The law requires that the death certificate be executed Box 68760. P.O. 1 Records. Division of Vital Physiclan: Hospital or Attanding Pi
 24 hours after death.
 Funeral Director: After the

Examiner Examiner ician and burial-transit physician s the burial Physician/Medical as signed b à page 2 should Completed this certificate director. Be 10 funeral Certification: filled in by within 24 hours a To the Funeral C completely filled

Physician

/Medical

Examiner

Funeral

Director

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Important: If any injury o once.

Physician

/Medicai

Health and Mental

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Pages 1 and 2 should

Baltimore, Maryland 21215-0020

must be notified at

Director

Funeral

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Completed

Be

25. Was cesa rafarrad to medical axaminar? 1 ☐ Yes 2 ☐ No 27. Mannar of Death 1 Alatural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida 29a. Certifian 1 Certifying Phyeicien: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examinar: On tha basis of exemination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mennar stated.

29b. Signatura and titla of certifiar

29c. Licansa numbar

29d. Data signad (Month, Day, Yaar)

D 47924

NOMAN THANWY 31. Date filed (Month, Day, Year)

30. Nama and addrass of parson who completed ceusa of death (Itam 23a) (Type, Print) 10 AURORA

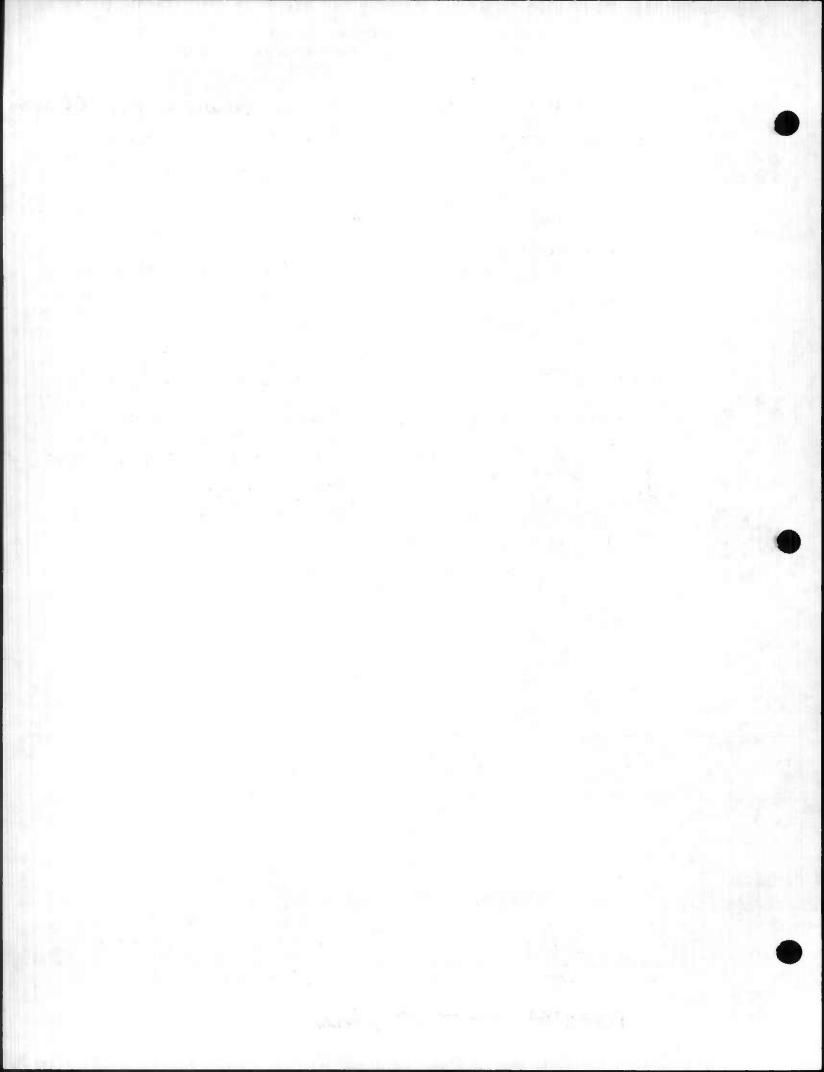
ST CAMBRIGE MO

State Registrar

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To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** 1605 1999 Sacit February 16 /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Union Memorial Hospital Baltimore n/a If Under 24 Hrs. 8. Date of Birth Month, Day, You Oct 30, 1 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** DOM 20 F 719-16-9577 70 Yrs. Director Turkey Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits Anne Arundel Severna Park 1 Yes 25 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 20 St. Andrews Road 21146 Berra 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [] Yes 2 2 No if Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0020 "natural", or white 1 Yes 20 No Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life: DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medicine 5+ Medical Doctor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Is Important: it less 7 is marked any injury or other Be Ali Riza Eren Zekiye (Unknown) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haldun C. Eren / son 2555 Pennsylvania Avenue, NW #1005, 20037-1651
of Disposition (Name of Page 10 20c. Location - City or Town, State Washington, DC 20s. Method of Disposition 20b. Place of Disposition (Name of Feb 19 Maryland National
Memorial Park 15 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Laurel, MD 1999 21 Attriature of Funeral Septice Licent 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 death. Do not enter the mode of dying, such as cardiac or Interval Between Onset and Death Physician immediate Cause (Final disease or condition resulting in death) /Medic al Hypo volemic Shock 24 HR Examine Failure Congestive Heart 10 yrs Exam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that installed events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1□ Yes 以ENo Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 225 No Certification: To 1 Minpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Attending 1.EDNatural 5 ☐ Pending 1 Yes 2 No or 24 hours after death e Funeral Director: A wishy filled in hours investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier edical 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only Within 2 ana) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

Deron 1 8 1999 201 E. University Parkway Baltimore Md. 21218 32. Registrar's Signature

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

OHCY

AT 243 8946 M8

February 16 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month LAMAX IRENE FITZGERALD February 24, 1899 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. 6 / 20 / 25 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1 □ M 2 🛛 F 235-14-6968 73 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show notified at MD Worcester Director Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23a or 208 15th St. 21842 Completed by Funeral 11. Maritai Stetus 12. Wes Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕱 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: tzanadá 3 Widowed 4 Divorced alth and Mental Hygiene. 27 Is marked other than "natural or traumatic event, the Medical E. 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Co-Owner 10 Bike Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clyde Evans Mary McCormick To 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is or other trai Robert Lee Fitzgerald/Husband 208 15th St. Ocean City, MD 20b. Place of Disposition (Name of cametery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State Pages nent of t 1 Burial 2 Cremation 3 Removal from State Department Important: I eny Injury o Sunset Memorial Park 2/27/99 Berlin, MD 4 ☐ Donation 5 ☐ ther (Specify) 22. Name and Address of Fecility Burbage Funeral Home Service Licensee 108 William St. Berlin, MD Jarta

Approximate Onset end Deeth

fmmediate Cause (Finel disease or condition resulting in deeth)

Physician /Medicai

Examiner

the

se esn for

signed t

this certificate has

in by the funeral

or Attending Physician: after death.

Director: After this certifica

Hospital 24 hours

To the Hosp within 24 hou To the Funal completely fi

The law requires that the death certificate be executed

P.O. Box 68760.

Records,

of Vital

Division

Examiner

þ

Be Completed

10

Certification:

Medical

3. Time of Easth

2137

Birthplace (State or Foreign Country)

10d. Inside City Limits

Yes 2 No

WICOMICO

USA

Specify:

21842

Race - American Indien, Black, White, etc.

white

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Physician/Medical

Due to (or es a consequence of):

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

Due to (or as a consequence of)

25. Was case referred to medical

290. Signature vist little of certifier

5 Pending investigation

6 Could not be determined

1XYes 2 No

27. Menner of Death

Neturel 2 Accident

3 Suicide

4 Homicide

23b. Did tobacco use contribute to the cause of death?

1 Yas 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings evailable prior fo completion of cause of death?

1 ☐ Yes 2 No

1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

Hospital: 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a, Certifier

Scartifying Physician: To the best of my knowledge, death occurred et the time, dete and placa, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) and menner stated.

29c. License number

death. Do not enter the mode of dying, such as cardiec or respiratory arrest,

29d. Date signed (Month, Day, Year)

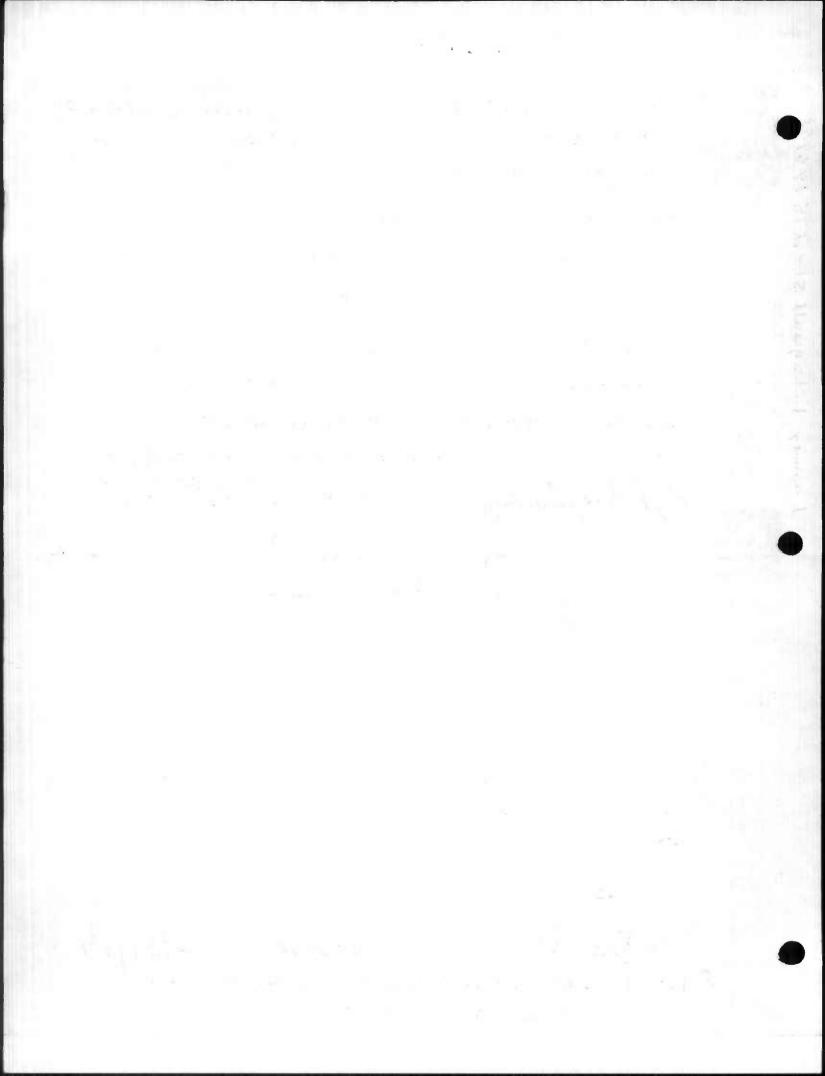
30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

DV. Je FFrey Wieland 400 E. Shore Dr. Salisbury rd. 21864 31. Date filed (Month, Day, Year)

28b. Time of

State Registrar

32. Registrar's Signature FEB 2 5 1999 ▶



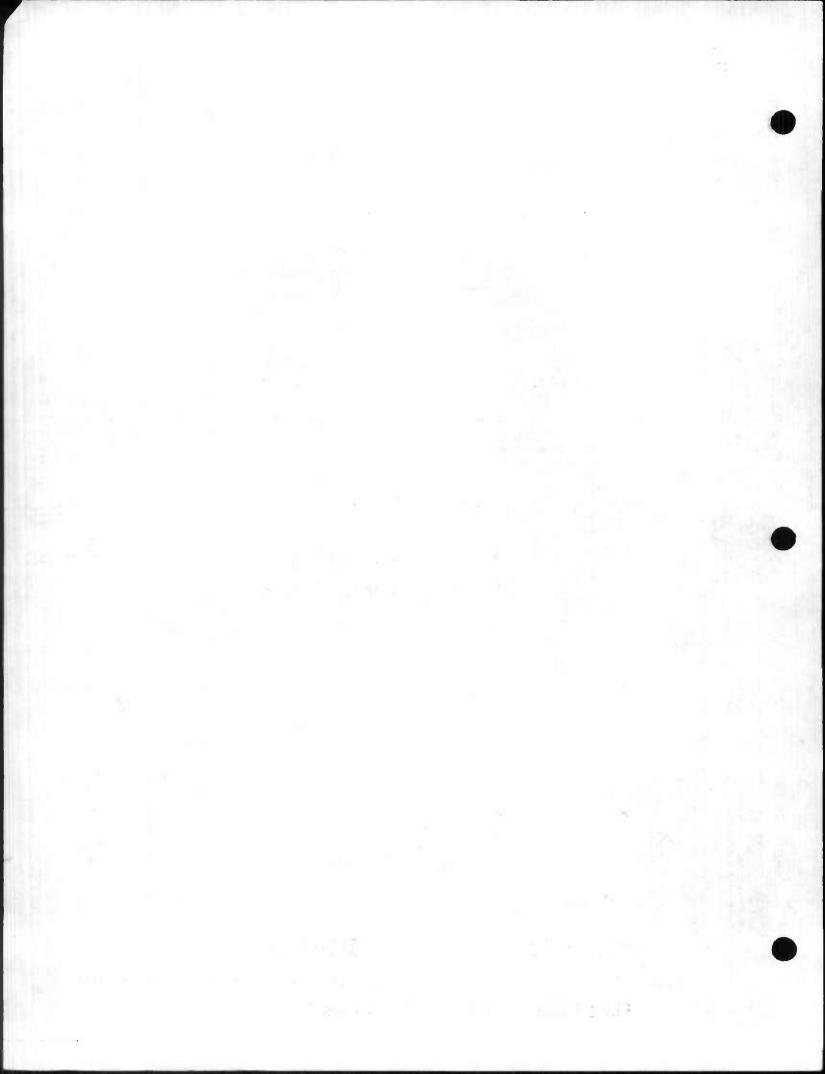
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. ITEM: #12 PER F.H. G770 4-30 State of Maryland / Department of Health and Mental Hygiene ITEM: #23B PER MD G769 3-17-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** B Fuller Erwin February 11,1999 7:10 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Dete of Birth (Month, Dey, Year) Mar 19, 192 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Montha 1XM 2□ F 73 219-14-0633 Maryland Director Usual Residence of Decedent 10a. Stafe 10b. County 10c. City. Town or Location 10d. Inaide City Limits 28a-f show MD Anne Arundel Severna Park 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 209 Avondale Circle 21146 USA Norte 23s 12. Wes Decedent Ever in U.S. Armed Forces? 1943-1 K Yes 250-If Yes, Give 1963 Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Marital Status filed within 72 hours after Hygiene. ther then "netural", or he 1 Never Merried 2⊠ Merried Baltimore, Maryland 21215-0020 white 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Postal Service Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahouid be filled with Department of Health and Mental Hygen Important: If Isen 27 is marrised other that any Injury or other traumatic event the Contracting Manager 17 Father's Name /First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Leslie B. Fuller Mollie Dols 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Katharine H. Fuller / wife 209 Avondale Circle, Severna Park, MD 21146 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Feb 15 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Meadowridge Cemetery 1999 4 ☐ Donation 5 ☐ Other (Specify) Dorsey, MD 22. Name end Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 21 Signature of Funeral Service Licens anco 495 Gov. Ritchie Hwy., Severna Park, MD 21146 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Dulated Cordinage per disease or condition resulting in death) terrs Examine Examine OFONORY physician end the buriel-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medicai Due to (or as a consequence of): 980 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No - Probably- 4 Unknown Records. à The law requires been signature 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 2 s 2 No 1 Yes 1 Yes 2 No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? edicai Certification: After or Attending 1 Natural
2 Accident 5 Pending investigation 1 Tes 2 No death. Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, ferm, streef, factory, office building, etc. (Specify) 6 4 ☐ Homicide hours efter To the Hospital o within 24 hours of To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D51560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS 21401 SIMONS 2003 MEDICAL PARKWAY MO (7PANT 31. Date filed (Month, Day, Year) FEB 1 6

Registrar

State

1999



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 7 0 6 Certificate of Death Reg. No. 2. Date of Death 3. Time of

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dev Month Year **Physician** Richard George Hill February 20, 1999 0750A /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner 12 Thyme Street Elkton if Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdev) **Funeral** Months Deys 1 XM 2 F Yrs. January 14, 1913 West Virginia 86 Director 232-10-1148 Usuei Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "neture!", or items 23a or 28a-f ahow unt: If them 27 is marked other than "neture!", or items 23a or 28a-f ahow unt; If the Maryland and the training a vent, I'm Margial Experiment right be inclined at 10d. Inside City Limits 10e. Stete 10b. County 10c. City. Town or Location 1 ☑ Yes 2 ☐ No Directo Maryland Cecil Elkton 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 21921 United States 12 Thyme Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Marine Survey 3 Self-employed 17 Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Sarah E. McIntyre Richard G. Hill 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 420 Cecil Street, Chesapeake City, Maryland 21915 Frank Hill/ Son 20c. Location - City or Town, State West Chester, 20b. Plece of Disposition (Name of cametery, cremetory or other piece) February 21, R.A. Ferris and Company 1999 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei from State permit. Page Department of Important: if any Injury or once. R.A. Ferris and Company Pennsylvania 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Hicks Home for Funerals, P.A. 21. Signeture of Funeral Service Licensee 103 West Stockton Street, Elkton, Maryland 21921 las Jarrel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physician and the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest Due to (or es a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequenca of): 88 usa Po signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evelleble prior to completion of cause of death? 24e. Was en eutopsy performed? Completed s certificate has b 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: director 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: After 5 Pending 1 Yes 2 No death. investigation 2 Accident a Funeral Director: A Funeral Director: A Pletaly filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ò Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) end menner stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature ordittle of certifie 29c. License number of person who completed cause of death (item 23a) (Type, Print) chegapente Hospice, Elkran, my 32. Registrar's Signatur State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Items #10b,c,e,f, 2/23/99, E.T WCHD Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death **Physician** Mary 6:48 Hussman /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nema (If not Institution, give street and number) Examiner General Hospital Worcester Berli, MD Atlantic ff Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Yrs. Birthplaca (Stata or Foraign Country) **Funeral** 212-30-6920 1 M 2 F MD Director Usual Rasidance of Dacedant the Menyland 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryla Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic avent, the Modical Examiner mast be northed as 1 Tas 2 No Director BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Kina Richard 21214 USA HERRING RUN DRIVE 4817 Funeral 12. Wes Dacadant Ever in U,S.
Armed Forcas?

1 Yas 277 No
If Yes, Give
Yaar or Dates: Race - Amarican Indian, Bleck, Whita, atc. Wes Dacedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Never Married 2 Married 1□ Yas 2₽ No Baltimore, Maryland 21215-0020 Specify: Specify HITE by 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be MARY A. MACK JOHN M. CUNNINGHAM 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) OCEAN PINES, MD., 9 KING RICHARD WINIFRED C. MURRAY 20b. Place of Disposition (Nama of cematary, cramatory or other place) Deta 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stata 2-19 SALISBURY . MD. 4 ☐ Donation 5 ☐ Othar (Specify) SALISBURY CREMATORY of Fundral Service Lice 22. Nama and Addrass of Fecility HOME BERLIN, ULLRICH FUNERAL Pat47 Enfar tha diseasa, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consaquance of): Examiner neumonia physician end s the buriel-transit certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Undarfying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or es e consequence of): 98 esn esn signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Wara autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? page 2 s hes 1 ☐ Yas 2 ☐ No 1 Yas 2 No certificate or Attending Physician: funeral director, Be 25. Was cesa refarrad to medicel axaminar? 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding investigation death. 2 Accidant after death 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 - Homicida 24 hours a Hospital 1 Certifying Phyeicfan: To tha best of my knowledga, daath occurred et tha tima, data end place, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the ceusa(s) and mannar stated. 29a. Certifian Medical completely (Check only one) To the To the To the F

10 State

Registrar

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

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29b. Signetura and fit)a of certifian

Berlini

Andrea K HoAman MD

29c. License number 001753612 29d. Date signed (Month, Day, Year)

AR A will the the telephone and give the

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P.O. Box 68760. of Vital Records.

> State Registrar

31. Dete filed (Month, Day, Year) FEB 2 5 1999

RODNEY A.

Jarrey

WENRICH, M.D. 32. Registrer's Signeture

a. Wennich M.D.

30. Name end eddress of person who complated cause of daeth (Itam 23e) (Type, Print)

100 POWER ST.

15384

SALISBURY MO

FEB. 23, 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Depar

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Exami	ner				oer)								unty of Deat	1	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No: 3. Tima of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Dey Month 10:15pm DAVID C HOLLY FEBRUARY 1999 12 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death ANNE ARUNDE 7. Age (In yrs. last birthday) If Under 1 Yea ANNAPOLIS ARUNDEL Birthplece (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex Months Deys 180 M 2□ F 216 01 9371 Yrs. 83 MARYLAND OCT.17,1915 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number UNITED STATES 21401 918 SCHOONER CIRCLE 12. Wes Decedent Ever in U,S. Armed Forces? 1▼ Yes 2 □ No If Yes, Give Yeer or Detes: ₩WII 14. Race - American Indian, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ **PROFFESOR** EDUCATION 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) JAMES GUNTER DAISY CHAUNCEY 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 918 SCHOONER CIRCLE ANNAPOLIS MD. 21401 CAROLYN HOLLY (WIFE) 20c. Location - City or Town, Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20e. Method of Disposition 1 ☐ Burlel 2€ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) FT. LINCOLN CREMATORY 02-15-99 BRENTWOOD . MD . 21. Signature of Theral Sovice License 22. Name and Address of Fecility JOHN M. TAYLOR FUNERAL HOME, INC 147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD. 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset end Death Immediate Ceuse (Final LIVER FAILURE 2 WKS diseese or condition resulting in death) Due to (or es e consequence of): 2 WKS CIRRHUSIS Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last 3 WKS DUODENAL ULCER Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 ☐ Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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h and Mental Hygiene. 7 is marked other than "natural", or items 23a or traumetic event, the Modical Examiner must be 1

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked other any injury or other traumatic event.

Directo

Funeral

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Completed

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records.

Division of Vital

Examiner

physician and the bunal-transit use as for ed by the a signed t should l After this certificate has funeral director, page 2

death certificate be Attending ne Hospital or Attendi n 24 hours after death. The Funeral Director: A sletely filled in by the fu death. To the F within 2. To the F

þ Completed Be 10 Certification:

edical

Physician/Medical

29e. Certifle (Check only one)

29b. Signeture end title of cartifier

25. Was case referred to medical

1 ☐ Yes 2X No

27. Manner of Death

1 Neturel 2 Accident

3 Sulcide

4 ☐ Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) end manner stated.

1 N Inpatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of

28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28c. Injury et Work? 1 Tyes 2 No

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

lexander MD

5 Pending

investigation 6 Could not be determined

D50016

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARBARA ALEXANDER MO FEB 16

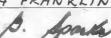
MD 21401 GH FRANKLIN ST, ANNAPOLIS

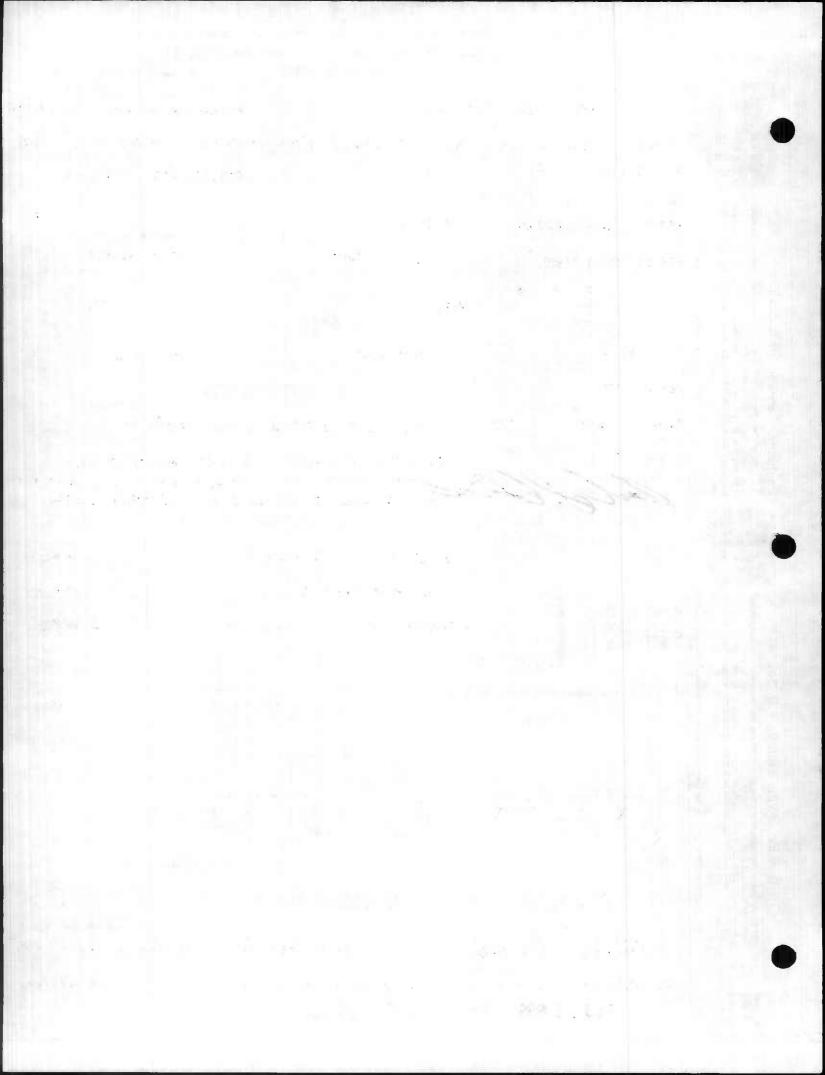
26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

State Registrar 32. Registrer's Signature





Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GERTRUSE 150N 6:48 PM E. FEBRUARY 16, 1999 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death NORTHWEST RANDALLSTOWN BALTIMORE CENTER HOSPITAL | If Undar 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 30, 1 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Days 1 M 2 4 F Months Yrs. 87 1911 212-05-1300 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6617 Marvin Ave. 21784 United States 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒No Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8th grade 18 Mother's Name (First Middle Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) John Frock Laura Coulter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wanda L. Blizzard 6617 Marvin Ave. Eldersburg, MD Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Ramoval from State 4 □ Dopation 5 □ Other (Specify) 2/19/99 Lutherville, Maryland Saters Baptist Ch. Cem. 22. Name and Addrass of Facility V Funeral Service License Burrier-Queen Funeral Directors, P.A. ell 1212 W. Old Liberty Road Winfield, MD 21784 Farth Erner tha disaasa, or complications that cause the date. Do not enter the mode of dying, such as cardiac or respiretory arrest, book, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION 1 HOUR Due to (or as a consequence of) Due to (or as a consequence of): Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undarfying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of deeth?

Physician /Medical Examiner

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requires that the death certificate be executed

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Physician:

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Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Certification:

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10a. State

Funeral

Director

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e filed within 72 hours after death all Hygiene.
other than "naturel", or items 23:

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic event

Baltimore, Maryland 21215-0020

with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Neture

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ◯ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28b. Time of 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Yes 2 No

28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Decilifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) and manner stated.

29c. Licansa number

mo

29d. Date signad (Month, Day, Year) 47587 FEBRUARY

1 Yas 2 Oo

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

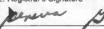
RANDALLSTOND MD 21133 5401 OLD COURT ROAD FINE, MD KOBENT 31. Data filed (Month, Day, Year) 32. Registrar's Signature

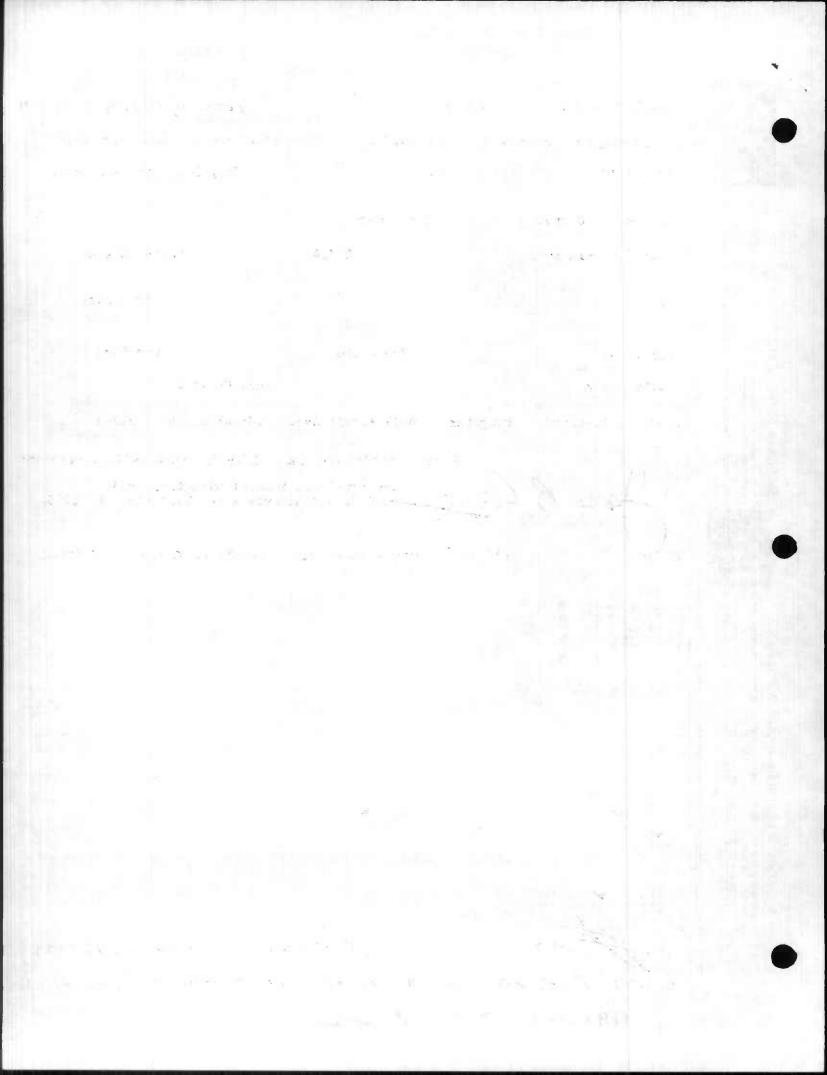
State Registrar

FEB 1 9 1999

5 Pending investigation

6 Could not be determined



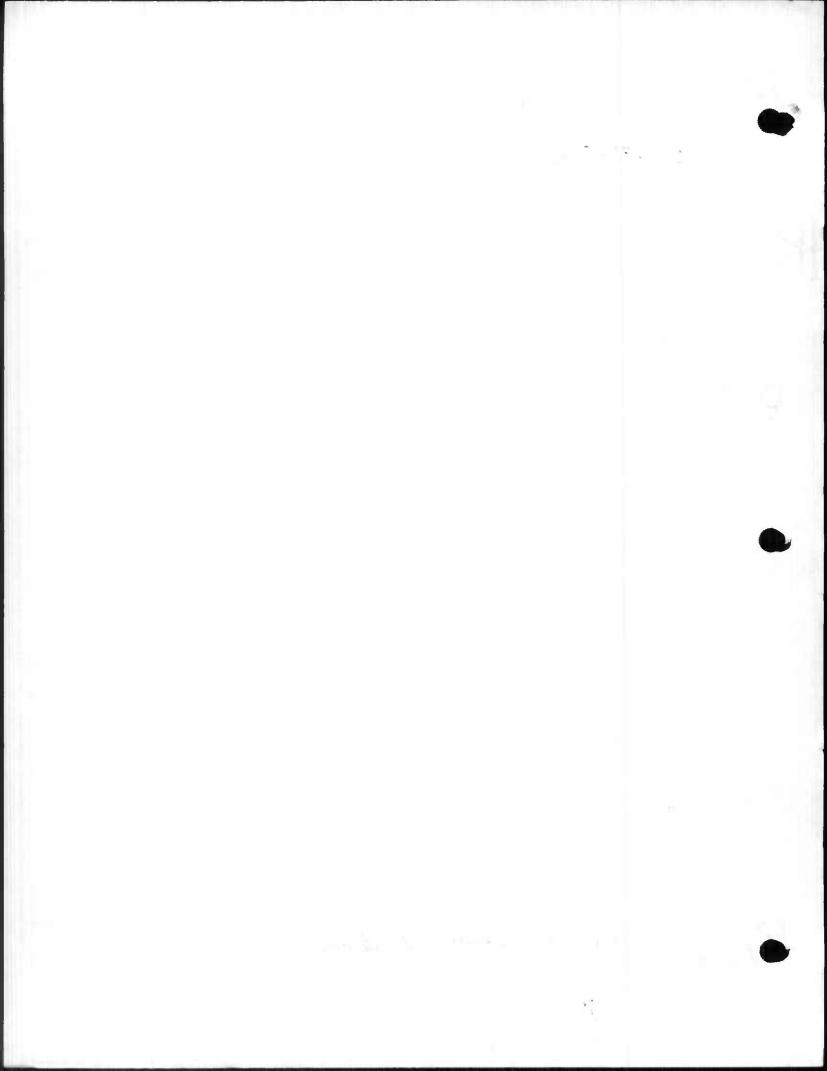


, or other traumatic event, the medical examiner m	any Injury, or other traumatic event, the medical examiner m	33 shows any Injury, or other traumatic event, the medical examiner managed to the second of the sec	or item 23 shows any Injury, or other traumatic event, the medical examiner m	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be no per contractions.
, or other traumatic event, the medical	any Injury, or other traumatic event, the medical	3 shows any Injury, or other traumatic event, the medical	or item 23 shows any injury, or other traumatic event, the medical	marked, or item 23 shows any Injury, or other traumatic event, the medical
, or other traumatic event, the	any Injury, or other traumatic event, the	3 shows any Injury, or other traumatic event, the same of the count, the same of the country of	or item 23 shows any Injury, or other traumatic event, th	marked, or item 23 shows any injury, or other traumatic event, the
r, or other traumati	any Injury, or other traumatic	3 shows any Injury, or other traumatives	or item 23 shows any Injury, or other traumative	marked, or item 23 shows any Injury, or other traumatic
r, or other	any Injury, or other	3 shows any Injury, or other	or item 23 shows any injury, or other	marked, or item 23 shows any Injury, or other
	any Injun	3 shows any Injury	or item 23 shows any Injury	marked, or item 23 shows any Injury
em 28 is marked, or item 23 shows	erren by puyerola	em 28 is marked,	eren	
ANT: If item 28 is marked, or item 23 shows	ANT: If item 28 is marked, or item 2	ANT: If item 28 is marked,	ANT: If item 28 is	ANT: If its

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Lest)

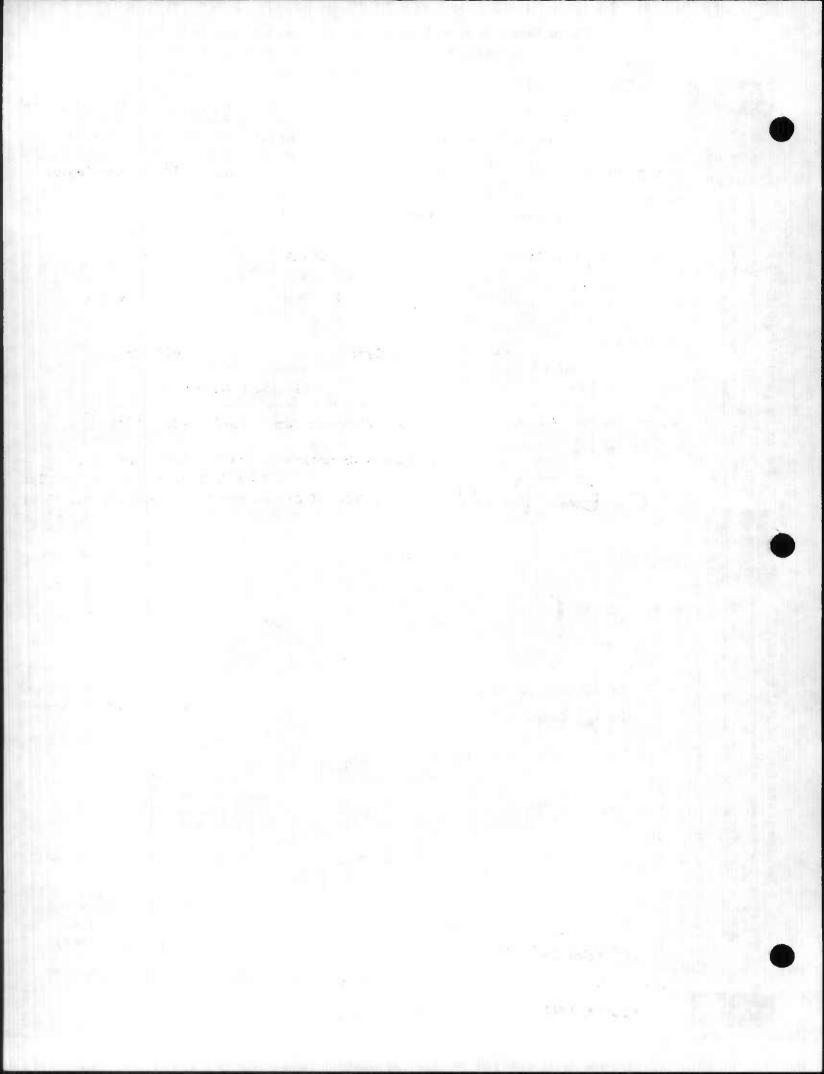
	HEGISTHAR		CERTIF	ICATE	OF DEA	TH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH D	AY YE	3. TIME OF DEATH
1	Henry Thomas 4. SOCIAL SECURITY NUMBER						02 14	99	
	214-34.5721	1)(M 2 F	(In yrs. lest birthday) 60 YRS.	MONTHS D	AYS HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year) 03-12-38	8. (BIRTHPLACE (State or Foreign Country)
m	9a. FACILITY NAME (If not institution, give s				WN OR LOCATE		ATH	9c. COUNTY	
DIRECTOR	RESIDENCE OF DECEDENT	dy Memoria						Some	rset
뿐	10a. STATE 10b. COUNTY			TY, TOWN OR L					10d. INSIDE CITY LIMITS?
	MD Some	rset	Cri	sfie]	101. ZIP COD			I son CUTUTEN	1 Y YES 2 NO
FUNERAL	254 Somers Co	ve Apt.			218			log. Grazen	S
FU	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS	DECENDENT (OF HISPAN	IIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	or No- 14.	RACE — American Indian, Black, White, stc.
) BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES		YES 2 1 NO				Specify:Black
TE	15. DECEDENT'S EDUI (Specify only highest grade	CATION completed)	16a. DECEDENT'S	work done durin	PATION ig most of world	ng	16b. KIND OF BU	SINESS/INDUST	RY
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u				Casta	d Tad.	
O	17. FATHER'S NAME (First, Middle, Last)		Labor	er	18, MOT	HER'S NAI	Seafoo		ISTTY
BEC	Hezekiah Jack	son			Net	tie	Cottman		
10	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (St	reet end Number	or Rural R	Soute Number, City or Tow	n, State, Zip Cod	le)
	Gertie Strasse					Ave	. Crisfi		
	20e. METHOD OF DISPOSITION 1 Densition Densit Densition Densition Densition Densition Densition D	oval from State ce	crematory or o	of disposition of the place of	™ <i>(Name of</i> netery	2	/20/99 M	CATION — CHY Brion,	or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		Ant	HONY	SS OF FAC	Ward Fun	eral H	ome
	Auch	2 Mari	XV.	314	Cove	St	. Crisfi	eld. N	ID 21817
	23. PART i. Enter the diseeses, or c shock, or haert felture.	complications that cause List only one cause on	ed t∦a death. Do each line.	not enter the	mode of dy	ing, such	n aa cardiac or reepi	ratory arrest,	Approximata intervai Between
	iMMEDIATE CAUSE (Finei disease or condition		Bome	Loons	a in chara				Onset and Death
	Due to (or as a consequence or): Due to (or as a consequence or): Mutas tata Caravina								
Z	Sequentielly liet conditions,	b	Meta	state	Carmi	ma			
ATIC	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE O	F):	, Care	instru	R.		
E S	CAUSE (Disease or injury that initiated events		A CONSEQUENCE O						
CERTIFICATION	resulting in death) LAST								
	PART ii. Other significent condition	a contributing to deetin	but not reauiting	in the under	iying cause (given in I	Part i. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
EDICAL							1 YES 2		COMPLETION OF CAUSE OF DEATH?
Σ	DID TORACCO LICE CONT	NOUTE TO CALLET							1 TYES 2 NO
AN	DID TOBACCO USE CONTE	RIBUTE TO CAUSE C	26. PLACE OF DEA			ERTAIN			
PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:		eidence (6 Other (Specify)		
并	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN		INJURY AT WORK?		28d. DESCRIBE HOW II	NJURY OCCURE	D O
ВУ	1 Natural 5 Pending 2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			YES 2	NO			
8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, farm, scify)	street, factory,	office		261. LOCATION (Street e City or Town, Stete)	nd Number or R	ural Route Number,
Ē	290. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my know	rladge death occurr	ad at the time	dets and place			5.5cm	
COMPLET									use(e) and manner se stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICE	NSE NUM	9ER	29d. DATE SIG	NED (Month, Day, Year)
		1 Wow	47		D1	5715	<u> </u>	2-1	8-99
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type	, Print)					
유		-		_					
P	William Gill 31. DATE FILED (Month, Day, Year)	Burton Av	er Cri	sfiel		218	317		
)L	William Gill	32. REGISTRAR'S SIGI	NATURE	Spor		218	317		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

									Death		Reg. No.	U	1010
Physician		nt's Name (Firs	•)		L				2. Date of D Month	Day	Year	3. Time of Death
/Medical			Roger			Joh	nson			Februa	-	799	8:25 AM
Examiner		Name (If not in			umber) Cence				4b. City, Town, or Cropfor		th 4c. County Anne		indel
Funeral Director	534-	32-5190	10	x XM 2□F	7. Age (In yrs 6.5		If Unde Months	r 1 Yaar Days	If Under 24 Hrs Hours Min	(Adonth F	irth Year), 1934	9. Birthp Cour Was	plece (State or Foreign htry) hington
ylend	Usual Resi 10a. State	dence of Deced	County		10c. C	ity, Town or Lo	cation					1	0d. Inside City Limits
vith the Mar nor 28a-f s be nourise Director	Md	. Pr	ince G	eorge		Bowie							1 ☐ Yes 2 🕅 No
or 28	10e. Street	and Number					10f. Zi	Code			10g. Citizen of V	Vhat Cour	ntry?
23a 23a Za	12	539 Win	dover '	Turn					0715		US		
urs after death with the Maryler lit, or flerns 23s or 28-4 show the result be notified at the Parket next Director.		Status ver Marriad 2 dowed 4 □ D		Armed F	cedent Ever in U forces? 2 No ive 19: Dates: to 19	54	Was Dece f Yes, spe 1 ☐ Yas		dispanic Origin? (s an, Mexican, Puer Specity:	Specify Yes or N rto Rican, etc.)		e - Americ ck, Whita, '' Whi	
n 72 hour		15. D (Specify only ery/Secondary	ecedent's Edu highest grad	cation le com <i>pleted</i> College	(1-4or 5+)	16a. Deced (Give life.			pation during most of wo d)	orking	16b. Kind of Bu		dustry
CO A B CO		a Blama /First	Middle Local	5+		Ana	alyst		10 Mathada Na	ma /First Middle	U.S. G		
d 2 should be filed within the end Mental Hygiene. It is marked overs, the the traumatic event, the the TO Be Comp		s Nama (First, I s tian J								eth Guer		13)	
2 should be shou	19a. Inform	nant's Name/Re	elationship (T)	rpe, Print)		19b. Mailir	ng Addres	s (Street	and Number or R	lural Route Num	ber, City or Town,	State, Zip	Code)
12 th	Barba	ra John	son / v	wife					r Turn	Bowie,	Md, 20	715	
emit. Peges 1 and 2 bepartment of Haelth emportant: If item 27 is ny injury or other transce.	1 □ 8	od of Disposition urial 2 \ Cren onation 5 □ C	nation 3 DF		n State	Place of Disponentery, cremetery, cremetery.				Date 2-17-99	Brentwo		
Departmen Important: any injury once.		ure of Funeral S			1.6					1	220110110		1 Home, Inc
permit. Departi	1	P- 1	suan	Pou	ell	1							,Md. 21401
Physician	23a. Parti shoc	. Entar tha dise k, or heart failu	asa, or compl e. List only o	ications that ne cause on	caused tha dea each line.	th. Do not ent	er the mo	de of dyir	ng, such es cardis	ac or respiratory	arrest,		Approximete Interval Between Onset and Daath
/Medical Examiner	Immediate disease or resulting in	Cause (Final condition deeth)		a	Pn-	eamonto							2 days
						or as a consec	uence of	:				1	/ week
hysician end the bunal-transit	Sequentia	lly list condition	s,	b		or as a consec	uence of	:	•				
ificete be axecuted g physician end as the bunal-transited edical Examile	d any, lead cause. Er Cause (Di	lly list condition ding to immedia iter Underlying sease or injury ad avents	le	c	Cen	ebrovasc	ular	A	-ccident				3 months
) # G & @	resulting if	death) Last		d	Due to (or as a conseq	uance of)						
eath cert attendin for use	D II OM			ntributing to death but not resulting in the underlying cause given in Part I.						Dah Di	d tehanan una an	maniferate A	o the cause of death?
v requires that the death certification is should be detached for use a feed by Physician/M	Part II, Oth	Lung	Canc		beath but not re	suming in tha u	noarlying	cause gr	ven in Part i.	1[bably 4 Unknow		
Physician: The law requires thet the death cent this certificate has been signed by the attending director, page 2 should be detached for use it. To Be Completed by Physician/N.		-								24a. We per	s en autopsy formed?	av	ere autopsy findings vallable prior to emplation of cause death?
The law page 2										10	Yes 2 No	11	☐Yes 2☐ No
ician: The li certificate he rector, page		ase refarred to	-							eth (Check only			
Physician: this certificated director,	1 □ Ye	s 219 No				ER/Outpatier		UA			sidence 6 Oth		fy)
ath. :: After the funera	27. Manne 1 12 Na 2 □ Ad	tural 5 🗆	Pending Invastigation	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time o Injury	М	28c. Inju Wo 1 □	ryat rk? Yes 2 □ No	28d. Describe	how Injury occur	red	
To the Hospital or Attending P within 24 hours effect death of the total Director. After tompletely filled in by the funeral Medical Certification:	3 □ St 4 □ He	uicida 6 □ omicide	Could not be determined	28e. Plac build	ce of Injury - At I ding, etc. (Spec	nome, farm, sti	eet, facto	ry, office		28f. Location City or T	(Street and Numb own, State)	per or Rur	a <i>l Route Number</i> ,
he Hospital in 24 hours he Funeral i pletely filled edical Ce	29a. Certil (Chec one)			nar: On the							e cause(s) and ma e, date and place,		
within 2 To the comple		ture and titla of	certifier				25	c. Licens	se number		29d. Date signe		
0 42 4	•	Mu	ma) Mu	D			D50	343		Februa	y 16	1199
		and address of		-	use of death (Ite	m 23a) (Type,		re	A-6	Bewie	Februa May la	ud i	20715
State Registrar		ed (Month, Day	, Year)	32.	Registrar's Sign		1.		,				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FERUARY 25 0005 NORMA E. KESTING 1999 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Yeer If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 M 4 X F Months Hours 216-20-2693 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 □ No OCEAN CITY MD. WORCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 152 JAMESTOWN 21842 RD. USA 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 20 Ae If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married 1 Yes a No Specify: SpecifyWHITE 3.5 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM G. RULEY MARY M. JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9145 ROBIN RIDGE DR., MECHANICSVILLE, VA. MICHAEL KESTING 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Seurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHELTEMHAN VETERANS CEM2-26 CHELTENHAM, MD. 22. Name and Address of Facility 21. Signature of Funeral Ser ULLRICH FUNERAL HOME BERLIN, 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one ceuse on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) . Ruptured Abdominal Aortic Aneurysm Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 4No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred

/Medical Examiner physician and the bunal-transit

Physician

Physician

/Medical

Examiner

Funeral

Director

na 23a or 28a-f ehow

"natural", or items ?

the Medical

If item 27 or other t

Directo

Funeral

P

Completed

Be

the Maryland

death

Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. not: If item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0020

3693

30

KESTING

VORMA

Examiner Physician/Medical attending pl signed by the a p this

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, funeral

Completed Be 10 Certification: after death Director: hours 24 hours Medical To the Hosp within 24 ho To the Fune completely fi

25. Was cese referred to medicel examiner? 14 Yes 2 No 27. Manner of Death 1ª Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Tyes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified michael 8. Buchney

29c. License number 02038 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 Pine Blue AROAL Suite 2. suite 25 Salisbury Md. 21801

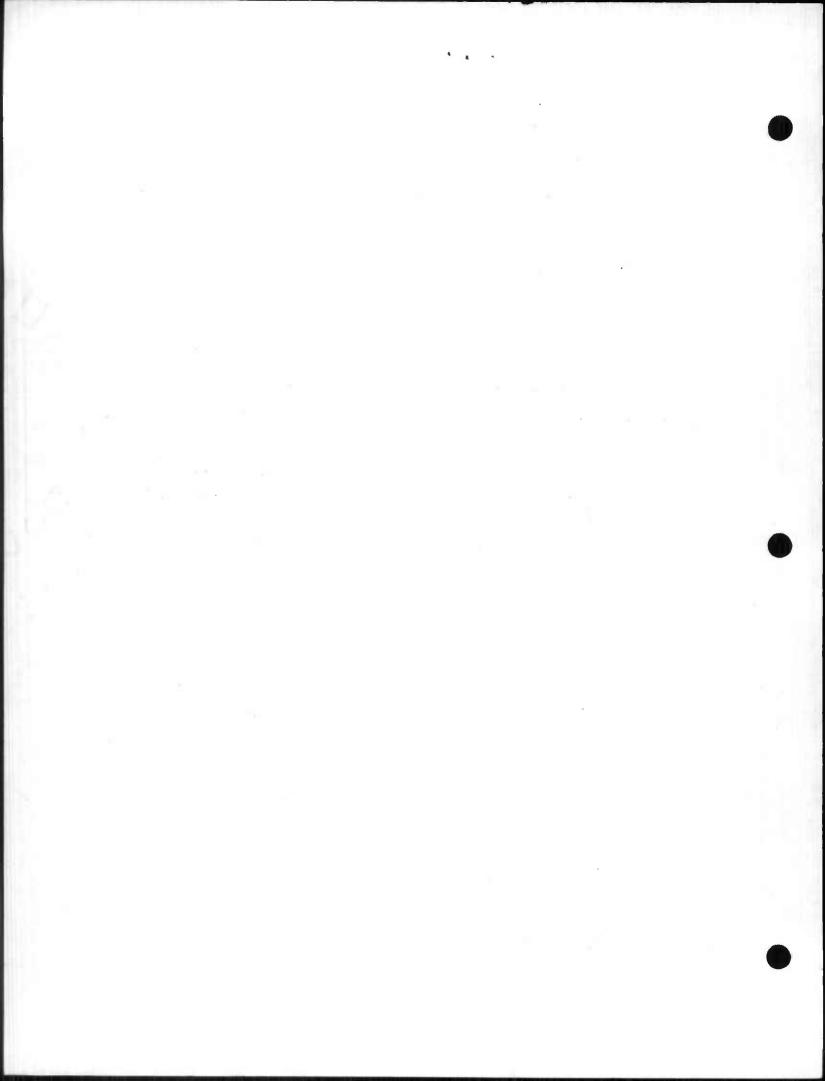
State Registrar

32. Registrar's Signature

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	ATE OF MARYLA		TMENT OF		MENTAL	HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) (SEORGE F. L	INKIN:	5			2. DATE OF MONTH			3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 577-03-8169 15	6. AGE (1)	r yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		BIRTH Day, Year) 29,19		Country)	ngton, DC
OR	9a. FACILITY NAME (If not institution, give street and I Meadow St. Apt. 2 RESIDENCE OF DECEDENT	_	Creek nunity	96. CITY, TOWN Berli	OR LOCATION OF DE	ATH		9c. COUNTY		
DIRECTOR	10e. STATE 10b. COUNTY Worceste			, TOWN OR LOCA Berlin	TION				100	I. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER				of, ZIP CODE			10g. CITIZEN		COUNTRY?
FUNERAL	I Meadow St., Apt.	207, Gull	Creek C		21811			US		
ВУ	1 Never Merried 2X Merried FC	PROCESS 1 YES YES, GIVE WAR OR DA	2X NO	If yes, s	CENDENT OF HISPAN pecify Cuban, Mexica S 2 NO Specify	n, Puarto Ric			Black, WI Specify:	American Indian, hila, alc. white
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete	(ed)	16a. DECEDENT'S (Give kind of v	vork done during n		16b. K	IND OF BUS	INESS/INDUST	RY	
1PLE	Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)	Owner-				Real	Estate		
	17. FATHER'S NAME (First, Middle, Last) George R. Lin	kine			18. MOTHER'S NA					
BE	19a. INFORMANT'S NAME (Type/Print)	INIIIS	19b. MAILING	ADDRESS (Street	Marga				de)	
7	G. Stephen Linkins				52, Ocean					342
	20e, METHOD OF DISPOSITION 1 Burlel 2 XCremellon 3 Removal fro 4 Donation 5 Other (Specify)		PLACE AND DATE Of all all all all all all all all all al			2-25	20c, LOC	rankf	or Town,	Delaware
	21. SIGNATURE OF FUNERAL BERGOT LICENSEE			The	ND ADDRESS OF FA Burbage illiam St.	Fune	ral Ho	ome,		
CERTIFICATION	Sequentisily list conditions, if any, laeding to immediata cause. Enter UNDERLYING	Cerebre Dye to (OR AS A	sch lina.	er K			ec or respir	atory srrest		Approximate Interval Between Onset and Desth Occy &
ERTIFIC	CAUSE (Disease or injury that initiated events resulting in daeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF	7):						
PHYSICIAN: MEDICAL CI	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 25 NO 11 11 11 11 11 11 12 14b. WI. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 25 NO 11									
SIAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	TH (Check only on		176		2		1 - (0)
IYSIG	1 = YES 2 NO 1 1 1	SPITAL: npetient 2 ER/Outp			me 5 🗆 Residence			R	2519	ence
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	Sep. TIM	URY W	JURY AT ORK? YES 2 NO	28d. DEŞC	RIBE HOW IN	JURY OCCUR	ED	
-		28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, s	street, factory, off	ce		TON (Street a Town, State)	nd Number or I	Rural Route	Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 1								tuse(s) an	d menner ee stated.
8	29b. SIGNATURE AND TITLE OF CERTIFIER	Bereslu	l'i	D	D280	MBER 69		29d. DATE SI	GNED (MO	nth, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO COM WICHOLAS N. B	PLETED CAUSE OF DE	TH (ITEM 27) (Type	Print) 170 FF	9 OCE	4N 156	HIGH	DE	/	9944
6	31. DATE FILED (Month, Day, Year) FEB 2 5 19	2. REGISTRARY SIGN.	ATURE	9. 60	acks		,			



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 17, 1999 **Physician** Robert Edward Lilev 9:00 am /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Spa Creek Rehabilitation Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) 55 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 12, Birthplaca (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min. 1944 255-62-6150 Massachusetts Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Fines 1 and 2 should be filed within 72 hours after death with the Marylan nant of Health and Mental Hygiena.

Intel Ham 27 is marked other than "natural", or items 23s or 28s-f show intell Ham 27 is marked other than "natural", or other traumatic event, the Medical Examinat must be notified as MD Anne Arundel Annapolis 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 134 Conley Drive 21403 USA Funeral 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 XYes 2 No If Yas, Give 1961-1982 Year or Dates! 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedant's Usuai Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT usa retired) U.S. Navy College (1-4or 5+) Elemantary/Secondary (0-12) Instrument Mechanic 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Father's Name (First, Middle, Last) (Unknown) Edith M. Carlson 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 134 Conley Drive, Annapolis, MD 21403 19a. informant's Name/Relationship (Typa, Print) Phyllis A. Liley / wife 20b. Piece of Disposition (Name of cemetery, cramatory or other placa) 20a. Method of Disposition Feb 22 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Glen Burnie, MD Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1999 Signature of Euneral Service Licer 22. Name end Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Do not enter the mode of dying, such as cardiac or respiratory arrest,

MD 21146
Approximate
Interval Between Approximate Interval Between Onset and Deeth Physician /Medical e Cause (Final 9 months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events dran-Due to (or as a consequence of): physician a the burial-Box 68760. Physician/Medical Due to (or as a consequence of): 8 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 6 8 signed by d be detact 1 XYes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 1 Yes 252 No 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 25No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28d. Describe how injury occurred 28s. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Affler Attending 5 Pending investigation 1 (SNatural 1 Yes death 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital or Att 24 hours after d Funeral Direct 4TTHomicide To the Hospital of within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D16364 30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

900 Bestgate Road, Suite 300, Annapolis, MD 21401

State Registrar Peter R. Graze, M.D.,

32. Redistrer's Signature

31. Date filed (Month, Day, Year) FEB 1 9 1999

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene (1)

					-	Certificate of		R	leg. No.	U	1014	
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	Physician /Medical Examiner	Je	23a. Pert1. Enter the disease, or compshock, or heart failure. List only of himmediate Ceuse (Final disease or condition resulting in death)	a	PNE	on one of the mode of dyl	ng, such as cerdiac	or respiratory arr	est,		Approximate interval Between Onset end Death	
(68/60,	rificete be axecuted ng physician and set the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Last									
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) U V	1-01			48098		FEB. 16,	1999		
			30. Name and address of person who c				way - Cri	sfield,	MD 2181	7		
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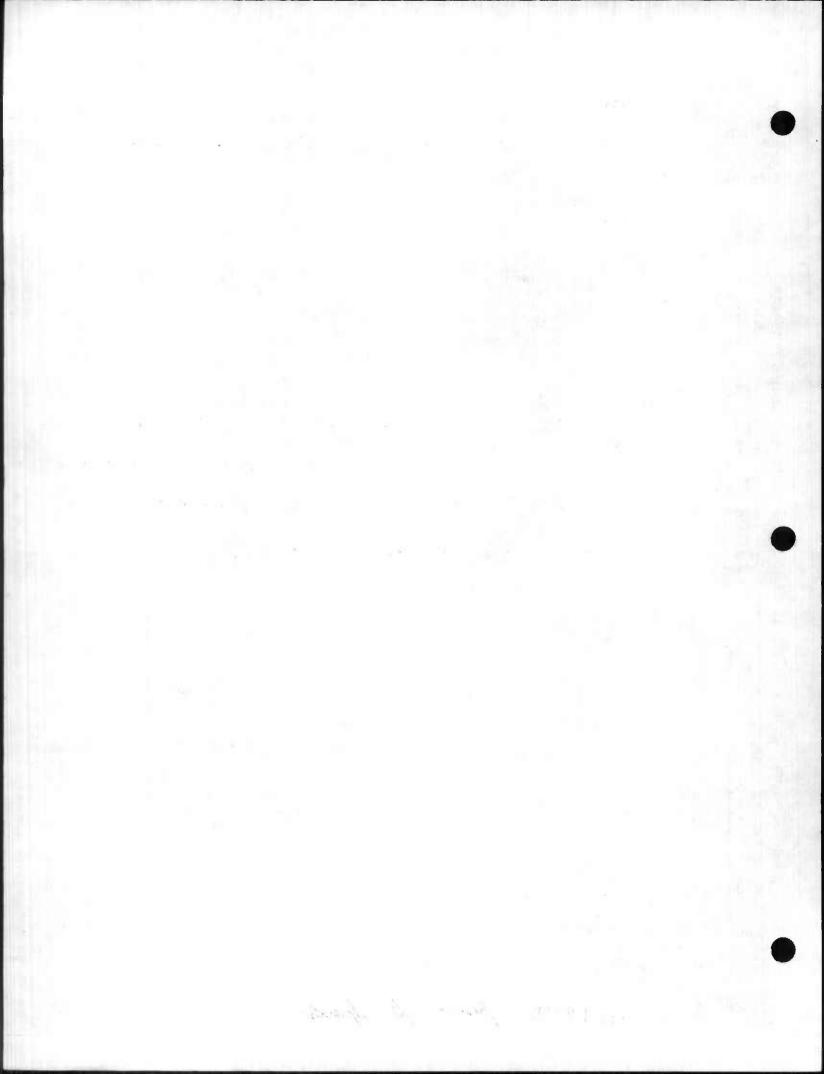
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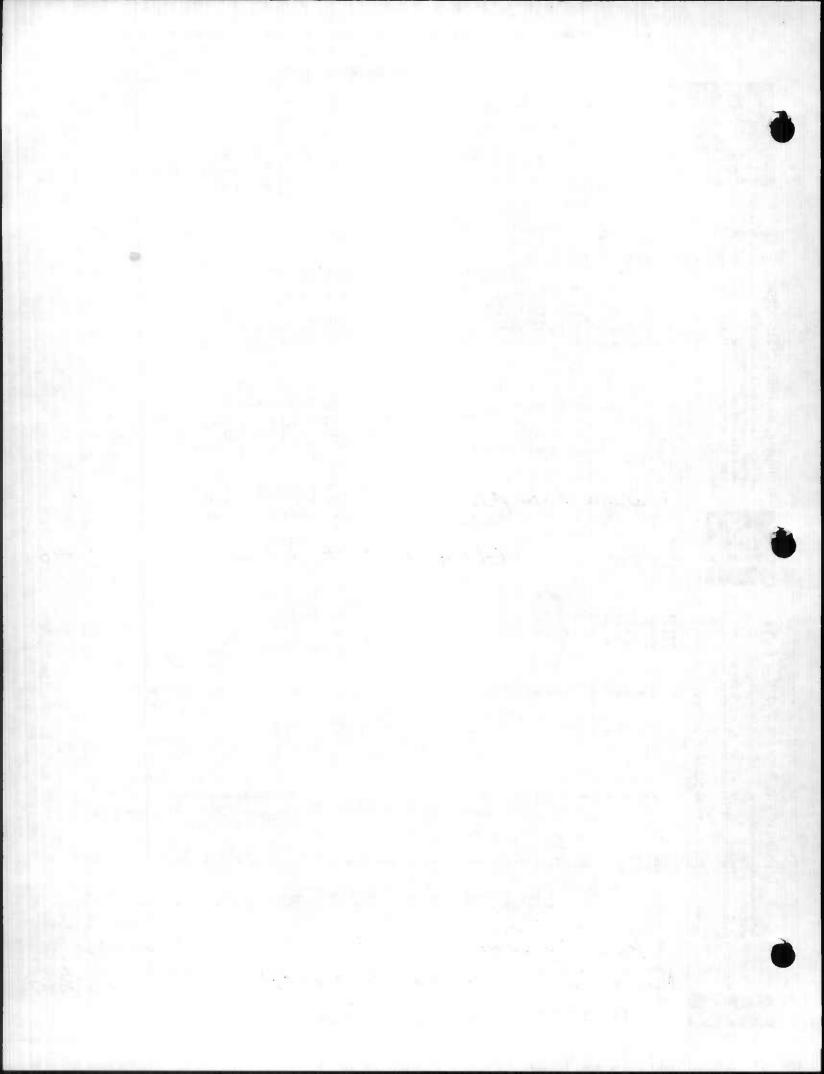
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Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ARCH J. MURRAY (a.k.a. Archibald James Murray) Feb /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 PA **Funeral** Days Hours 15M 20 F Months 219 18 9404 78 1920 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes & No Director MARYLAND CARROLL WESTMINSTER 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 515 HOOK ROAD 21157 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 12D Yes 2 □ No WW I I If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Married Specify: WHITE 21215-0020 'natural', or 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Other then "n College (1-4or 5+) Elementary/Secondary (0-12) OWNER/OPERATOR PARTS Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be next of Health and Mental WILLIAM ARCH MURRAY CATHERINE CASEY 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If Item 27 is any injury or other trau 515 Hook Road, Westminster, MD 21157 Margaretha E. Murray/wife 20a. Method of Disposition 20b. Place of Disposition (Nama of cametery, crematory or other piece) 2/22 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from Stete
Donation 5 Other (Specify) Green Mount Ave Mausoleum Baltimore, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 91 Willis Streett MYERS FUNERAL HOME Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the shock, or heart tailure. List only one cause on each kne. not enter the mode of dying, such es cardiac or respiratory errast, Approximata Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) 23 daxs Pnew monitis Examiner Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediata causa. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Pulmonary Fibrosis þ 24b. Were autopsy tindings evailable prior to completion of cause of daath? Atrial fibrillation 24a. Was an autopsy performed? Completed

Be Certification: To Attending after death Director:

Piabetes Mellitus 25. Was case reterred to medical axaminer?

1 Yes 2N No 27. Manner of Death

1 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide 4 Homicida

6 Could not be

28a. Date of Injury (Month, Day Year)

Hospitat: 1 Inpatient 2 ER/Outpatlent 3 DOA

28e. Place of tnjury - At homa, tarm, street, tactory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

281. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

28d. Dascribe how injury occurred

26. Place of Death (Check only one)

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

29b. Signeture and title of certifier

29a. Certifier (Check only one)

> 29c. License number 00052479

FebRuary, 19, 1999

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LISA Kim, m.O. at Carroll County General Memorial Avenue, Westminster, MD 21157 Hospital at, 200

State Registrar 31. Dete filed (Month, Day, Year) FEB 2 2 1999

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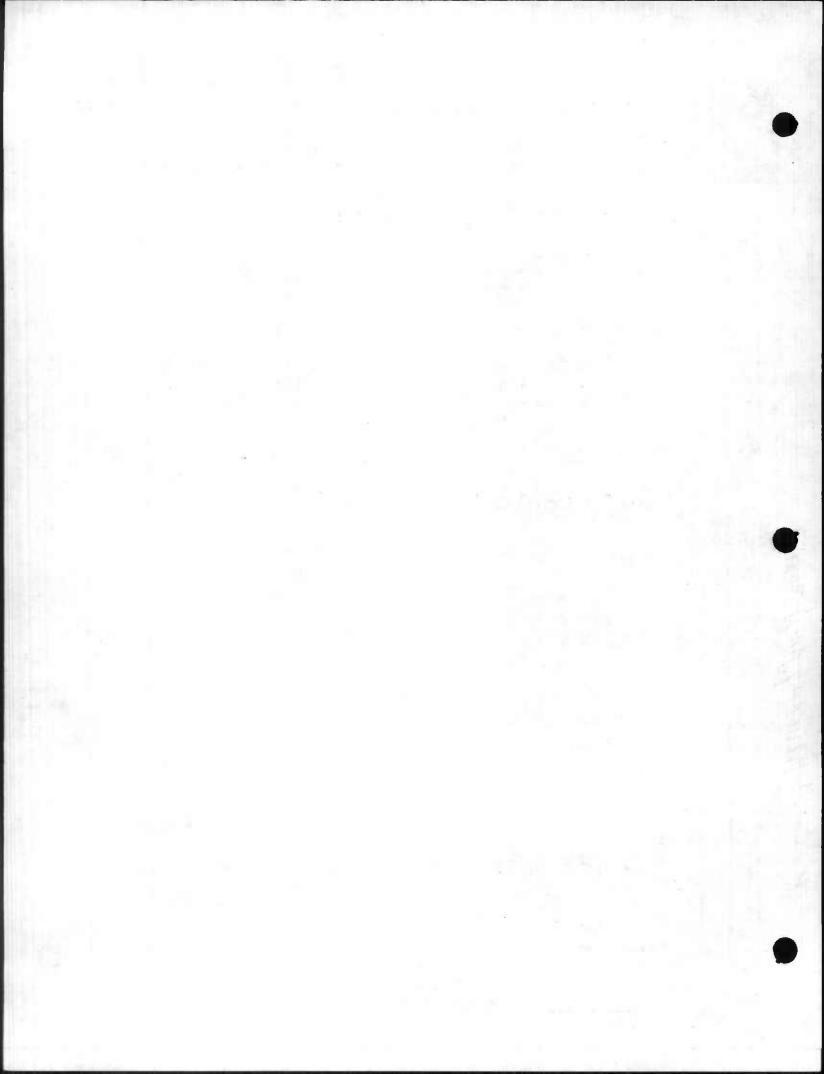
32. Registrar's Signeture

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hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

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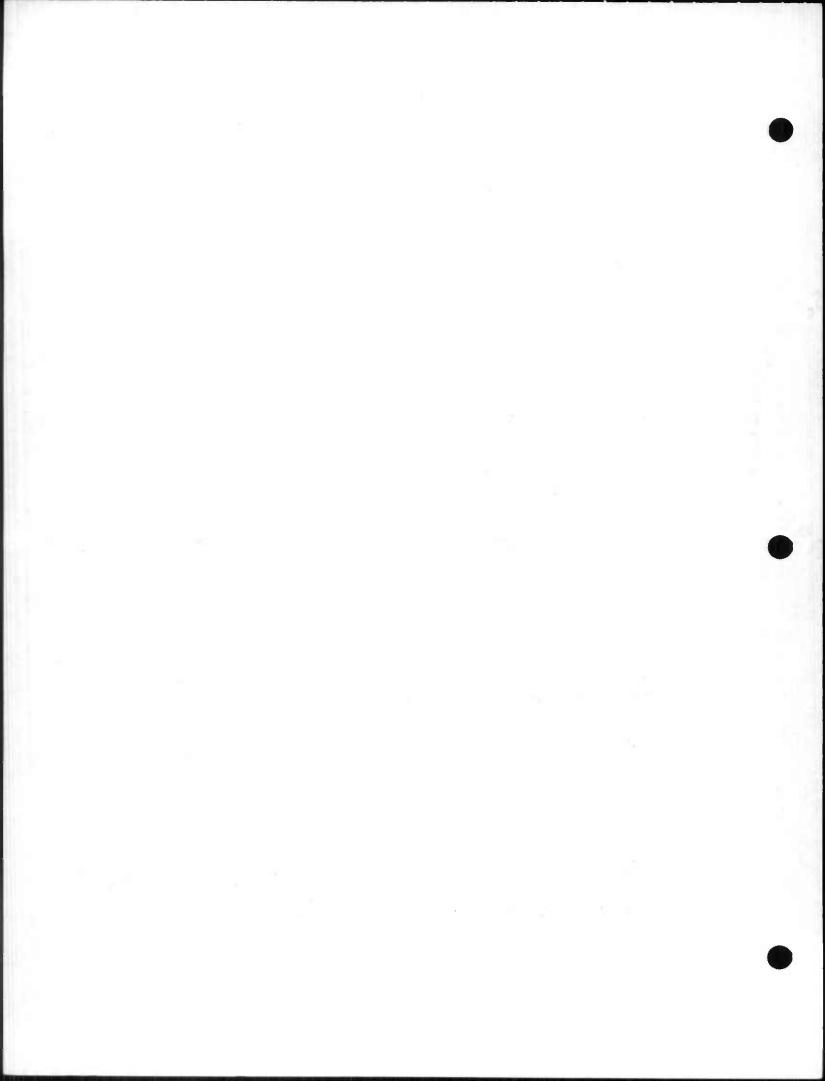
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF CEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH Grace E. Myers Feb.18 1999 5:50A.M. 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 - M 2 -DAYS HOURS 219-56-5201 90 Oct.30,1908 MD 9e. FACILITY NAME (If not institution, give street end number, 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH DIRECTOR 3957 Littlestown Pike Westminster Carroll RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? MD Carroll Westminster 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3957 Littlestown Pike 21158 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 4NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 HO Specify: 1 Never Merried 2 Married BY 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 18e. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondery (0-12) E College (1-4 or 5+) COMPL Homemaker Housewife at once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Meiden Surname) Edward Keefer Minnie Halter notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) Doris Brewer 3957 Littlestown Pike Westminster, MD21158 -Daughter pe 20a., METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION — City or Town, State DATE must St. Mary's Cemetery 2/22/99Silver Run, MD examiner 22. NAME AND ADDRESS OF FACILITY Little's Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Littlestown, PA17340 medical 23. PART I. Enter the diseases, or complications that caused the death on hot enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between shock, or heert fellure. List only one ceuee on each line Onset and Death IMMEDIATE CAUSE (Final the diseese or condition REGURGITATION MITRAL resulting in death) traumatic event, OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury or other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO INSUFFICIENCY shows any COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? CARONARY ARTERY DISEASE 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: item 23 s 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 4 Nursing Home S Residence 8 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 10 TO THE HOSPITAL OR ATTENDING PHYSICIA
TO THE FUNERAL DIRECTOR: After this cert
be filed within 72 hours after death with the
IMPORTANT: If Item 28 is marked, or 27, MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending м 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER

Charle onto 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner as stated. 296. SIGNATURE AND TULE OF CERTIFIER 29¢ LICENSE NUMBER John bollalla BE MO22239E 30 MAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 47.7 9 S. WASHINGTON 50 GETTYSBURG PA. 31. DATE FILED (Month, Dey, Year)
FEB 2 2 1999 32. REGISTRAR'S SIGNATURE

Geneva



Amended Item 19b, per F.D., 2/25/99, Carroll County, wjl Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 10g, per F.D. 2/24/99, Carroll County, wj1 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Year 20, 1999 Physician Joseph A. McGuire February 2:30 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Age Guest Home Sykesville Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Sep 24, 19 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months ₩ 2 D F 87 Yrs. 356-18-9131 **Director** Usuai Residence of Decedent with the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limita Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, the Modical Examinar rount by notified at 1 ☐ Yes Ž☐ No Director MD Sykesville Carroll 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21784 USA Golden Age Guest Home death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indien Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours efter a Department of Health end Mentel Hyglene. Important: If Item 27 is marked other than "natural", or iten any injury or other treumetic svent, the Med cell Exercited 2028. 1 Never Merried 2 Merried 1 ☐ Yes ≥ No Specify: altimore, Maryland 21215-0020 by Specify: White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Railroad Retirement College (1-4or 5+) Elementary/Secondary (0-12) Claims Adjustor Board 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether'a Name (First, Middle, Last) Elizabeth H. Moore Patrick Joseph McGuire 2 19e. Informent's Neme/Reletionship (Type, Print) (SOn) 19b. Malling Address (Steet and Number or Rurel Route Number, City or Town, State, Zip Code) 21784

Sykesville, MD 21784

7079 MacBeth Way, Sykesville, MD Mr. Joseph Edward McGuire 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) Date Feb 23 20c. Location - City or Town, State 20a. Method of Disposition Buriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Crestlawn Memorial 1999 Marriottsville, MD 22. Name end Address of Fecility
Haight Funeral Home & Chapel , P.A. 21. Signeture of Funeral Service Licanses of Haight brean P.O. Box 195 Sykesville, MD 23a. Pert1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Dullestia certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or as e consequence of): attending physician and for use es the buriel-trer Box 68760 Physician/Medicai Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. the 1 Yes 2 No 3 Probably 4 TUnknown signed by Division of Vital Records, þ 3 24b. Were autopsy tindings aveilable prior to Completed 24e. Was an autopsy performed? completion of cause of death? 99 1□Yea 2₺No 1 □ Yes 2 No certificate Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerei 28d. Describe how injury occurred 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: M After 1 Neturel 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide 6 24 hours Hospital 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and menner stated. (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 0 22 1999 Feb. D20806 auldus 30. Name and address of person who completed cause of deeth (frem 23a) (Type, Print) Patrick Turnes 1425 Liberty Road, Eldersburg, MD 21784

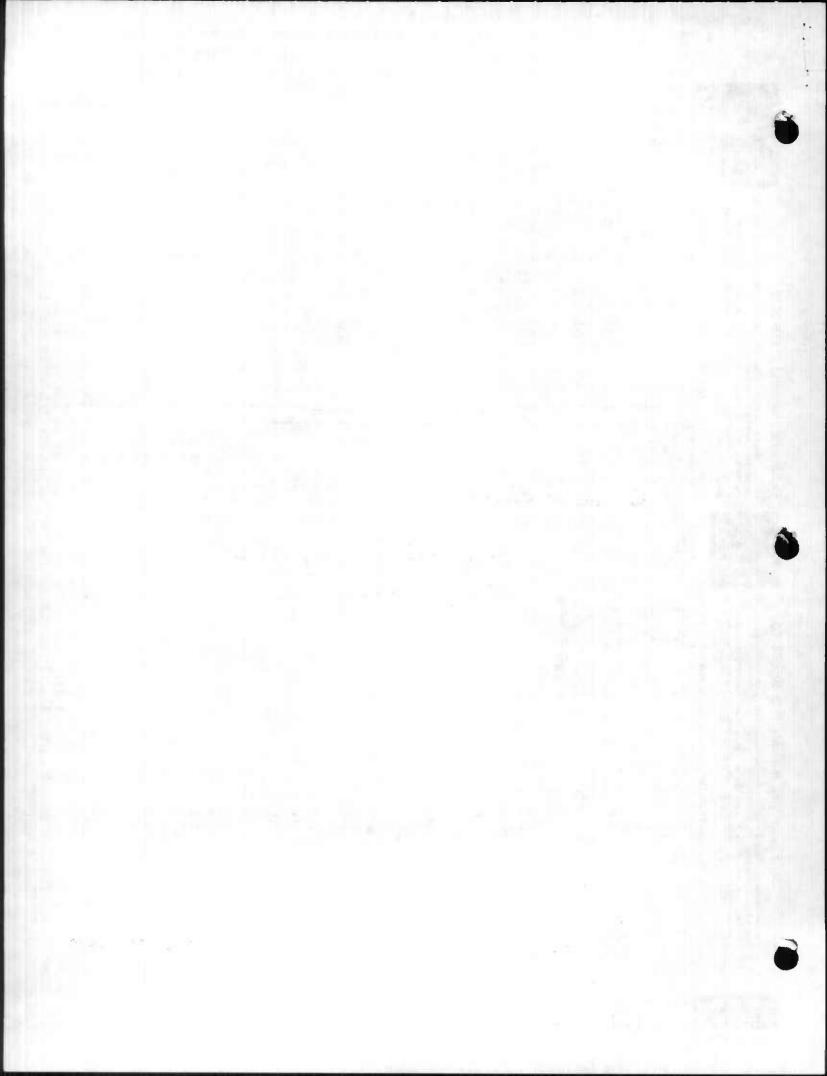
32 Registrar's Signature

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Registrar

31. Dete filed (Month, Dey, Yeer)

FEB 2 2 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedant's Neme (First, Middle, Last) Month February 15,1999 4:27 am Edward Ernest Markoya 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not Institution, give street and number) Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) Days Hours 1X M 2□ F Yrs. 76 Dec 8, 1922 339-18-4420 Illinois Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d, Insida City Limits Anne Arundel Severna Park 1 Yas 2 No 10f. Zip Coda 10g. Citizan of What Country? 10e Street and Number 600 McKinsey Park Drive, Apt. #104 21146 USA 12. Was Dacadant Evar in U,S. Armed Forcas? Was Decadant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amaricen Indien, 11. Marltai Status Black, Whita, atc. 1 XYas 2 □ No If Yas, Giva Year or Datas: WWII 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yas 2 X No Specify: white 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Grinder Steel 12 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Mary Dzuir John Markova 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Pat Markoya/ wife 600 McKinsey Park Dr., Apt. #104, Severna Park, MD Feb 16 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Othar (Specify) 1999 22. Nama and Addrass of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Cardiogenic 10 rus Dua to (or as a consequanca of): enjourn or Dua to (or es e consequance of) Due to (or es e consequance of): gostwentuits 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yea 2 000 3 Probably 4 Unknown 24b. Wera autopsy findings aveitable prior to complation of causa of daath? 24a. Was an autopsy Mus. Non insular

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760,

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pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mental Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent, the Medical Examinat must be notified at ence.

altimore, Maryland 21215-0020

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initieted events rasulting In daath) Last

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

6 Could not be datamined

Hospital: 1 Hopatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify)

26. Place of Death (Check only ona)

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28a. Data of Injury (Month, Day Year) 5 Panding Invastigation

28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how Injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one)

3 Suicida

4 Homicida

Certifying Phyalcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signatura and titla of certifier

DO8314

30 Name and address of person who complated causa of death (Itam 23a) (Type, Print)

MO

Day, Year) 16

32. Registrar's Signatura

205 Ridgely Aul Annopolis, MD 2401

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:00 pm FEB 10 1999 TRACEY MOORE /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner ANNAPOLIS ar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 29 W. WASHINGTON STREET APT. 412 A ARUNDEL 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplece (Stata or Foraign 6. Sax Months Days 1 XM 2 F Yrs. MARYLAND 216-68-9823 1957 **Director** Usual Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL 1 X Yas 2 □ No ANNAPOLIS Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? US 29 W. WASHINGTON STREET APT. 412 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - Amarican Indian. Black, White, atc. 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INTERFAITH CARE GIVERS INTERFAITH CARE 12th GIVERS 4 yrs. 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) CLAUDE COATES BETTYE JONES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health en. Important: If Item 27 ie m. eny injury or other WASHINGTON, D.C. 1601 UPSHURE STREET N.W. KIM MOORE (SISTER) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ANNAPOLIS MEM. GARDENS 2/15/99 ANNAPOLIS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Aport shock, or heart feiture. List only one cause on each line. lesse Approximate Interval Between Onset and Death fmmediata Cause (Final diseese or condition resulting in deeth) Trocky conder or Examiner cudidules Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated avents resulting in deeth) Last Sickled and Physician/Medical Dua to (or as a consequence of) Part II. Other afgnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings avellabla prior to 24a. Was an autopsy performed? Completed Viral Syndemil complation of cause of death? 2 No 1 Yas 1 Yes 2 No 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1□ Yes 2 No 10 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Deeth Certification: 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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Physician

/Medical

Examiner

treumstic event.

altimore, Maryland 21215-0020

98 USB signed t Division of Vital Records, page 2 uneral or Attending efter death. Director: Aft Hospital 24 hours hours within 2 To the \$

State

edical

29e. Certifier

(Check only one)

29b. Signeture and title of certified

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.

29c. License number

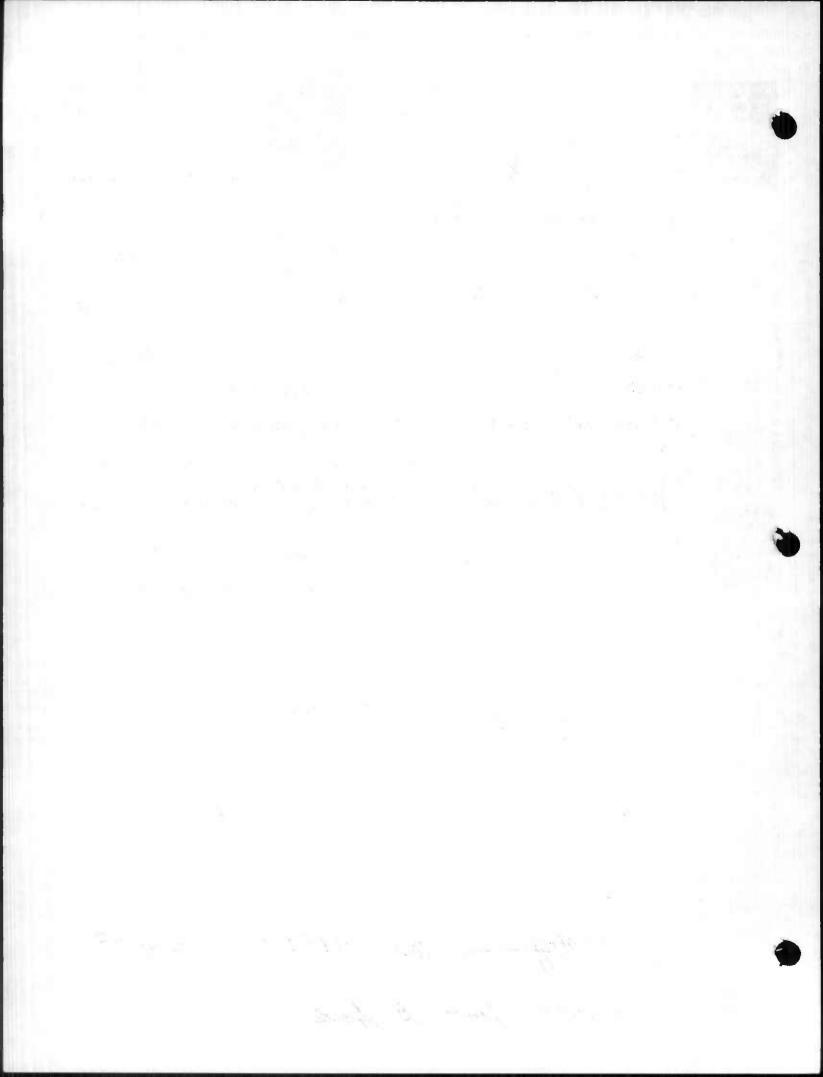
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State of Maryland / Department of Health and Mental Hygiene

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	yand Mand			County		10c. City,	Town or Loc	ation				10d	I. Inside City Limits
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	or 28	Director	10e. Street and Number 10f. Zip Code								10g. Citizen of	What Country	17
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death February 1999 1:30 Overholtz 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Death Westminster Carrall Carryll Cumty Gm 6 Sm Hunder 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign Months Days 1 M 2 F Sept. 29, 1902 MD 218-20-0765 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Carroll 191. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 14. Rece - American Indian, 4101 Old 21771 Was Decedent Evar in U,S. Armed Forces? 1 Yes 2 DNo Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No If Yes, Giva Yaar or Datas: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tood State SCIVICES 17. Father's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) Bertha Smith Howard 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD. 2 Dete 20c. Location - City or Town, Stata Allen Overholtz Kd. 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 20b. Place of Disposition (Nema of cemetery, crametory or other place) den Linthicum Cenetery 2.20-99 Clarksville, MD 22. Nama and Address of Facility Pitts Funeral Home, chapel, P.A. 4/2 Washing ton Rd. Po not enter tha mode of dying, such es caldiac or respiretory errest. Approximata Interval Between 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service License 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 Yas 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 1 Yas 25 No TSUnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation ↑ Natural 1 Tes 2 No

physicien at the burial ate has been signed by the attandin page 2 should be detached for use Division of Vital Records, certificate or Attending Physician: funeral director, After this To the Hospital or Attendir within 24 hours effer death. To the Funeral Director: Af Illed in by

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permit. Pages 1 and 2 ahould be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, the Ma

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

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Physician/Medical Examiner Completed by 8 Medical Certification: To

25. Was casa refarred to medical axaminer?

2 Accident 3 ☐ Suicide

6 Could not be 4 Homicide

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Westminster

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar es stated.

2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end mannar stated.

(Check only one)

29e. Certifier

MY

29c. License number 000 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) BOAITE 200 KOFi memorial

31. Data filed (Month, Day, Year)

FEB 2 2 1999

32, Registrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 8:45 p.m. ABORNE PRICE 1999 February 19 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 06. Sex MARY LAND MEDICAL SYSTEM

6. Sex | 7. Age (In vrs. less birthdev) | If Under 1 Yes BALTIMOVZE UNIVERSITY n/a If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Urider 1 Year | Months Days 5. Social Security Number Birthplace (State or Foreign Country) Funeral Days 11XM 2□ F 219-34-0377 61 February 5, 1938 North Carolina Usual Residence of Decedent the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Directo "natural", or hams 23s or 25s-f edical Examiner must be notifie Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 171 Marley Road United States 21921 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. 11. Marital Status of Hygiene. Other after de other than "natural", or them Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Plate Room Coordinator Graphics 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Pages 1 and 2 about be fill ment of Health and Mental H annt If Item 27 is marked off jury or other traumatic even Be Roea Price Jinny R. Howard 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances I. Price/ Wife 171 Marley Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, crematory or other place) Church of Christ 1 ☐Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of important: If any injury or pope. February 23, 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 1999 | Elkton, Maryland 22, Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 West Stockton Street, Elkton, Maryland 21921 Danued 1 ehrs) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical renal failure Examiner Due to (or es e consequence of): Examiner poteusin that the death certificate be assouted physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ble to (or es a consequence of): Box 68760, Seps18 Physician/Medicai Due to (or as a consequence of): Mantle cell lymphonia attending p . 080 Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown algned b b 24a. Wes an autopsy performed? Completed 24b. Were autopsy findings evailable prior to completion of cause of death? certificata has b 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: T s after deeth. It Director: After this certificat ad in by the funeral director, p B 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hoepital or within 24 hours aft To the Funeral Discompletaly filled in 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner es stated.

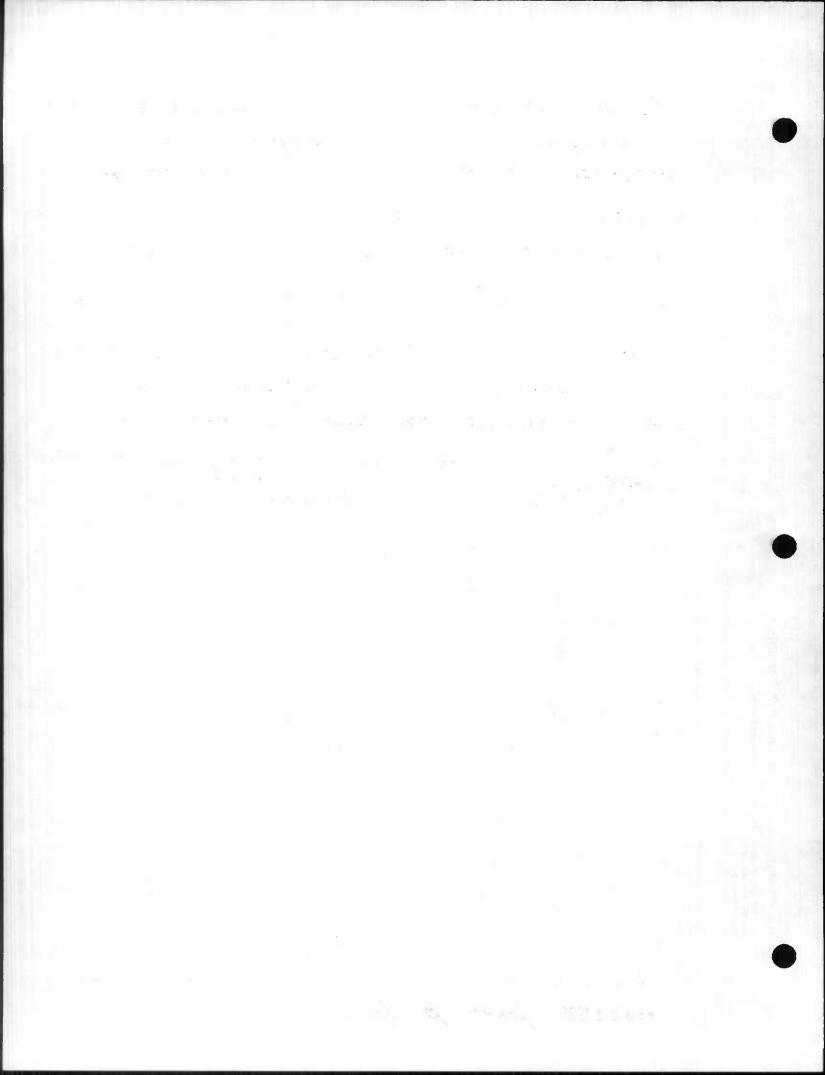
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 28405 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.WAZARIAN M.D 22 S. GREENE ST. BALTIMORE, MD 21201 31 Date filed (Month, Day, Year) FEB 2.2 1999 32. Registrar's Signeture Registrar

Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Daath Month Year **Physician** Pford + 0757 Maude FEBRUAR 1999 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deet/ 4c. County of Death Examiner Cec. EIKton Hospital UNION If Undar 1 Year | If Undar 24 Hrs Months Days Hours Min. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Months 1 M 200 F Pennsylvania 196-03-7431 Director May 9, 1907 Usual Rasidanca of Decedant Pages 1 and 2 should be filed within 72 hours after death with the Manyland neat of health and Mertal Hyglens. And the marked other than "heturel", or items 23a or 28a-f ahow thi: If team 27 is marked other than "heturel", or items 23a or 28a-f ahow any or other traumatic event, the Medical Examines must be notified at 10d. Insida City Limits 10a Stata 10b County 10c. City. Town or Location 1 Yas 2 No aryland Cec. FIKton Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code Apartments USA 14 Chesapeake 21921 Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Wes Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ∰ No If Yas, Giva Yaer or Detes: 14. Race - American Indian, 11. Marital Status Black White atc 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 👿 No Specify: Specify: White by 3 D Widowad 4 □ Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Spacify only highast grada complated) Elamentary/Secondary (0-12) Collaga (1-4or 5+) SALES RefleseNATIVE 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Elizabeth Lemeana Walter Cooper 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Department of Health elimportant: If item 27 is eny injury or other training #80 S. Shore Road, Elkton, mD. 21921 Pfordt -F. William 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Feb. 20,1499 West Chester, PA. Ferrisa-Co. 22. Neme and Addrass of Facility 21. Signature of Europeal Service Licansea Gee Funeral E1Kton, mD. 21921 259 E. Main St. 23a. Pert1. Enter the dease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 5 days neumoniA Examiner Dua to (or as a consaquance of): Examiner P To the Hospital or Attending Physician: The lew requires that the death certificate be executed within £4 hours afferdeath.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the innest director, page 2 should be deteched for use as the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consaguança of) Part tl. Other stgniflcent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Wera autopsy findings eveilable prior to completion of cause of daath? Completed Presno Holax 24a. Was an autopsy performed' 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No No Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Matural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 I Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29a. Cartifiar 29b. Signatura and titla of cartifie 29c. Licanse number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated cause of death (Itam 28a) (Type, Print) Exples PUZA mothy 31. Dete filad (Month, Day, Year) 32. Ragistrar's Signeture State FEB 2 2 1999 Registrar



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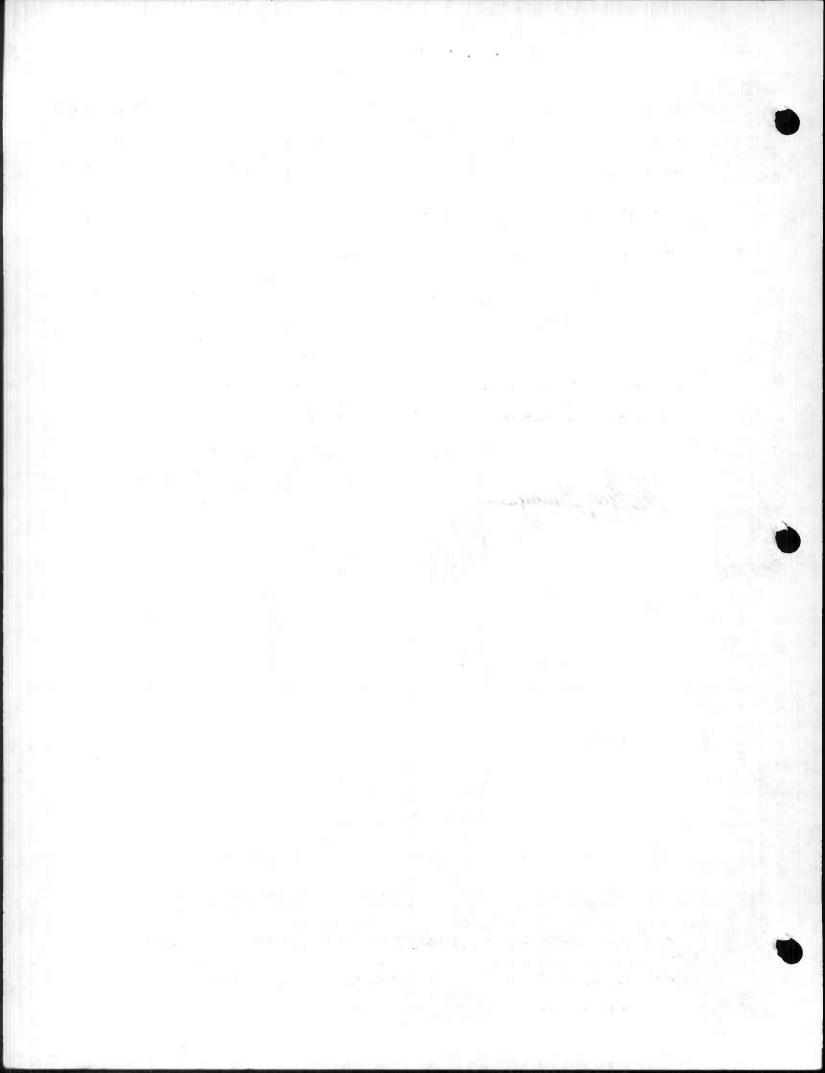
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Dete of Deeth **Physician** Month **PATTERSON** FEBRUARY 20 1999 6:50 PM WILLIAM HOWARD /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Berlin Nursing & Rehabilitation Center Berlin Worcester If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Maryland Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 M 2□ F Hours 79 Yrs. 218 09 0707 Director Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location a or 28a-f show 10d. Inside City Limits Maryland Worcester Ocean City 1X Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Counfry? death with "natural", or items 23a U.S.A. 21842 187 Beachcomber Lane Funeral 12. Wes Decedenf Ever in U,S. Armed Forces?

1X2 Yes 2 □ No If Yes, Give Year or Date 1:940-45 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, Whife, etc. 11. Marital Stetus filed within 72 hours after 1 ☐ Never Married 2 Married 21215-0020 Specify: White 1 Yes 2 XNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced The Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health end Mental Hygiena. ant: If item 27 is marked other than ury or other traumatic event, tra Me Elementery/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be James Howard Patterson Alice Davis 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 187 Beachcomber Lane Ocean City, MD Margaret Ann Patterson 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 XCremetion 3 ☐ Removal from State Department of important: If any injury or 4 ☐ Donetion 5 ☐ Ofher (Specify) Cape Henlopen Crematory 2/21/99 Frankford, DE Service Licansee 22. Name end Address of Fecility 108 William St. Burbage Funeral Home Berlin, MD 21811 diamase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Approximete Interval Between Onsef and Death **Physician** EXOVASCULAR DISEASE /Medical Immediete Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) PERTENSION pital or Attending Physician: The law requires that the death certificate be associated ours after death.

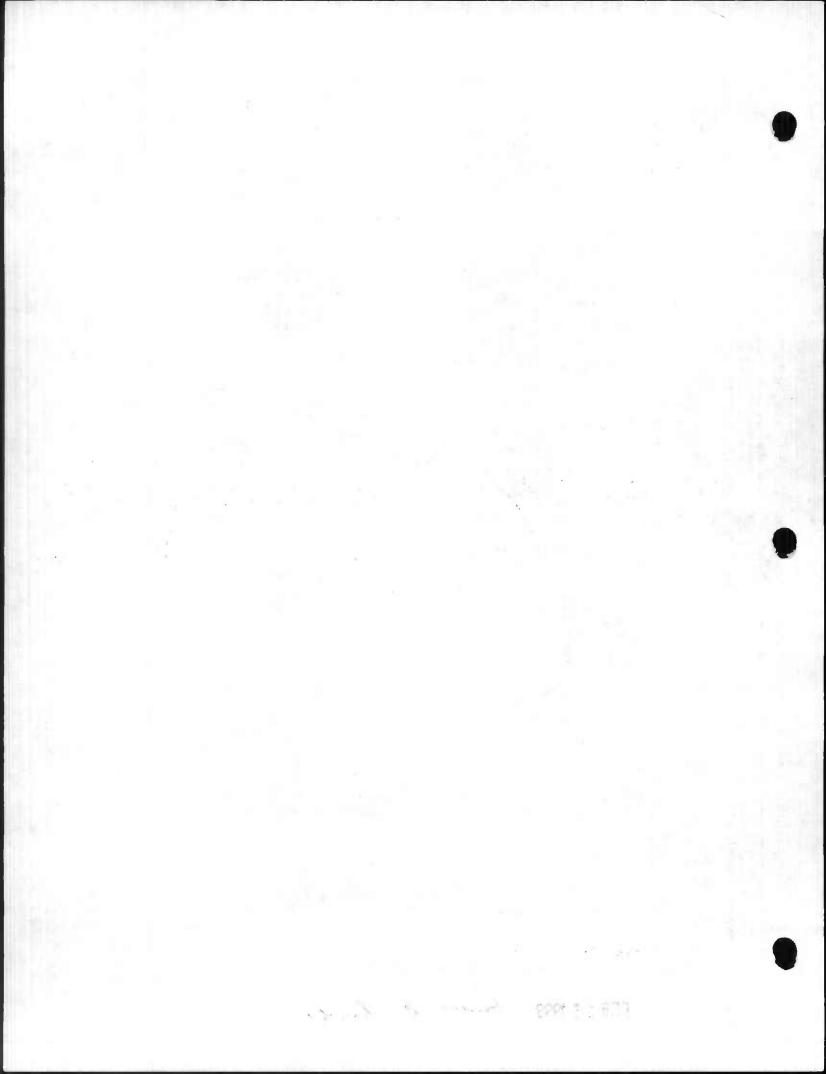
The set of the set of the set of the set of the attending physician end filled in by the Innerial director, page 2 should be detached for use as the burial-transit filled in by the Innerial director, page 2 should be detached for use as the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting In deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by t pege 2 should be detach 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, 2 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 K No 1 ☐ Yes 2 X No Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) To 1 Yes 2 X No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Deeth 28e. Defe of fnjury (Month, Dey Year) 28b. Time of 28c. Injury af Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, sfreet, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D completaly filled i 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner steted. Medical 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Edwin t. Castaneda, M.D. 314 Franklin St. Berlin, MD 31. Date filed (Month, Dey, Yeer) 32. Registrer's Signeture State FEB 2 2 1999 Registrar



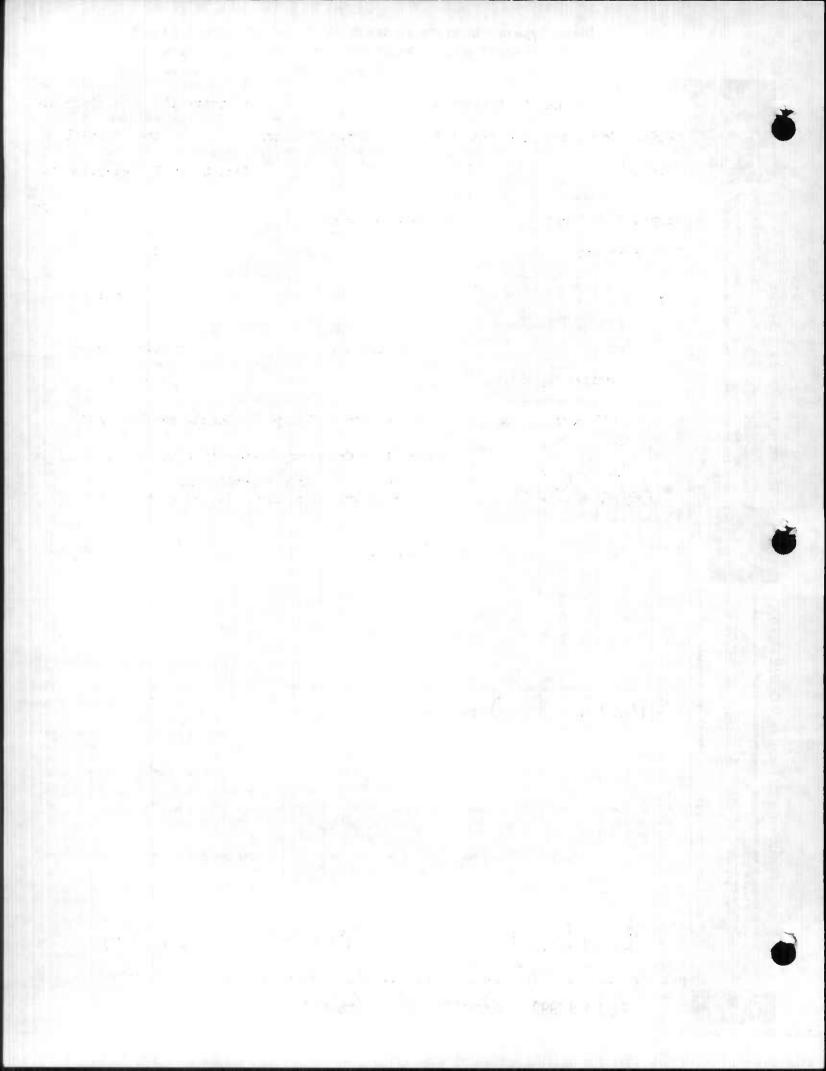
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er	5. Social Secu 213-56		S HOPK	ins H	Month	tal Bal er 1 Year If Under 24	thrs. 8. Date of Bi Min. Oct 6,	rth ay, Year)	9. Birthplace (State or Country) Maryland	
Completed by Funeral Director	Usual Resider	10b. County	1	0c. City, Town o	or Location				10d. fnside City	
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	10e. Street an	d Number			10f. Z	ip Code		10g. Citizen of V	Vhat Country?	
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		Married 2 Merried wed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 XNo if Yes, Give Year or Detes;	er in U,S.	If Yes, sp	edent of Hispanic Originacity Cuban, Mexican, 125 No Specify:	Puerto Rican, etc.)		a - American Indian, ck, White, etc.	
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/Medical Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											
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Funeral Director		9x 7. Aga (In yrs. 71		Inder 1 Yaar hths Days	Hrs. 8. Date of Bir (Month, Da Dec 8	th y, Year) 1927						
pur *	Usual Residence of Decedent 10a. Stata 10b. County	10c. C			10	d. Inside City Limits						
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vith the Ma or 28s-f s be notified	10e. Street and Number			f. Zip Code			10g. Citizen of V	What Count	ry?			
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al, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yas 2 No If Yes, Give Year or Dates:	100	ecedent of I specify Cub es 2 No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Rac Blac Specify	e - America ck, White, e	tc.			
"natural",	15. Decedent's Ed (Specify only highest gra		16a. Decedent's	Usuel Occup	petion	working	16b. Kind of Business/Industry					
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Hygiene. other than ent, tre M			Super	visor	10 Matharia	Nome /First Middle		0	Company			
a se se	17. Father's Name (First, Middle, Last) Millie Ma	rchin			18. Mothers	Agnes	me (First, Middle, Maiden Sumama) Agnes (unknown)					
marked	19a. informant's Name/Relationship (7		19h Mailing Ad	drace /Stract	and Number o	or Rural Route Numb			Code)			
000	Gary G. Pilipovic					eake Beach						
7 5 5	20a. Method of Disposition		Place of Disposition camatery, crematory			Date Deach	20c. Location -					
nt: If Ib	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	tropolita			2-15-99	2-15-99 Alexandria, Virginia					
portar portar y injur	21. Signature of Fuheral Sayescoption				114,	111611114						
of a g	> What Mills	2		_		Funeral Ho		MD	01007			
nysician	2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Consett and Dea											
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within 24 hours after death To the Funeral Director: / completely filled in by the f Medical Certificat	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fa ify)	actory, offica		28f. Location (City or To	Street and Numl wn, State)	ber or Rural	Route Number,			
Funer fely fill		yaician: To the best of my kni Inar: On the basis of examin- and menner stated.										
within 2 To the comple	29b. Signature and title of certifier	A		29c. Licans	se number		29d. Date signe	d (Month, L	Day, Year)			
7. 0	1 Insluhe	1./		03	5848	3	2/15	199				
	3p. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	.1	0	1						
	Howard K Schultz	Jr. 1438 De		Huy	Gam	brills her	0 210	54				
State	31. Date filed (Month, Day, Year)	32. Pegistrar's Sign	eture	1	,							



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death

Maryland 21215-0020

altimore,

6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier 🔀 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner statad. 29b. Signature and title a certifier 29d. Date signed (Month, Day, Year) 29c. License number

Lynzia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D47518 February 6, 1999

AANC Franklin as Cathed St ANNAPILIS, mo Buck Therese cw 31. Dete filed (Month, Day, Yeer) FEB 1 6 1999

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. .. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year BERTHA LEE REYNOLDS February 18, 1999 0205 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Laurelwood Nursing Center F1kton 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days Months 1□M 2円F 92 Yrs. May 30, 1906 Maryland 216-24-7419 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1E Yas 2 No Maryland Cecil Charlestown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 249 Black Avenue 21914 United States 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Her own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Theodore Heverin Esther Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 463, Charlestown, MD John W. Palmer / Son 21914 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a Method of Disposition 20c. Location - City or Town, State Dete Feb. 22 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1999 Charlestown Cemetery Charlestown, Maryland 21. Signature of Funeral Se PACE Libense 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumenia 3-4 days disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 → thknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Directo

Funeral

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Completed

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Funeral

Director

i Hygiene. other than "natural", or herns 23e or 28e-f show yent, me Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer death N Deportment of Health end Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23s any injury or other treumatic event, the Medical Examinar must policie.

altimore, Maryland 21215-0020

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Examiner Physician/Medical þ Completed Be Certification: To

68760. Box (P.O. Records. Division of Vital or Attending Physician: To the Hospital or Attendir Within 24 hours etter death. To the Funerel Director: A 3 filled in

> 0 State Registrar

completely

Medical

29b. Signature and title of contiling

31. Date filed (Month, Day, Year) FEB 2 2 1999

Kenzulli

5 Pending

investigation 6 Could not be

1 Yes 2 ₹No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Warburtan

28a. Date of Injury (Month, Day Year)

44102 Kd

29c. License number

28c. Injury at Work?

1 Yes 2 No

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ELKTON

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

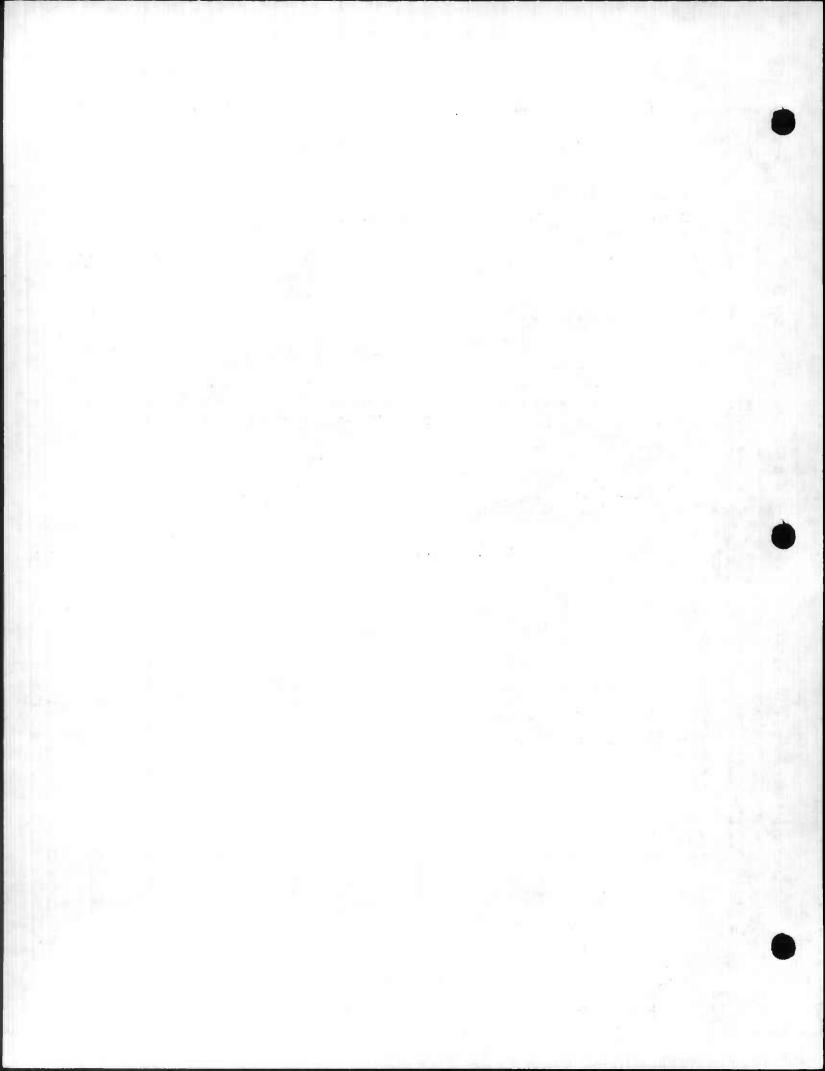
28d. Describe how injury occurred

62. Registrar's Signature oaks

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of



Physician /Medical Examiner be executed ettending physician and for use as the buriel-transit

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ò Hospital To the Hospital within 24 hours e To the Funeral C

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Records, P.O. Box 68760

Division of Vital

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7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effect Department of Health and Mental Hygiene. Important: If hem 27 is marked other than "natural", or iter any Injury or other traumatic event, the Marian Example.

Baltimore, Maryland 21215-0020

the Maryland

death

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Physician/Medical

> 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Deeth

28e. Date of Injury (Month, Dey Year) 5 Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

29e. Certifier (Check only one)

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signeture end title of certifier

Drogan

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29d. Date signed (Month, Dey, Yeer) February 17 1999

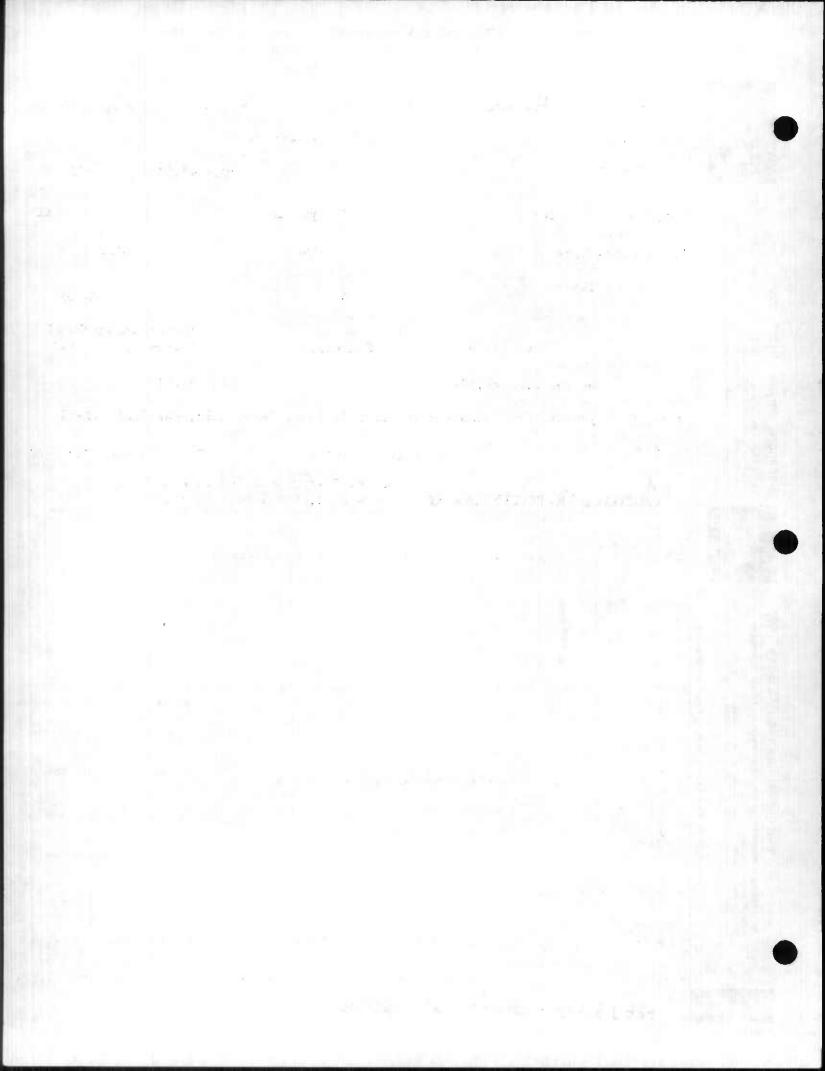
30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) Grogan

Johns

4940 Eastern Avenue Hopkins Bayu. en Medical Center Baltimore MD 31324

State Registrar 31. Date filed (Month, Dey, Year) FEB 1 9 1999





State of Maryland / Department of Health and Mental Hygien® O Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 13, 11:56 pm Joanne Yvonne Rummel Feb. 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner University of Maryland Medical System Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Data of Birth (Month, Day, Year) **Funeral** Months Days 1□ M 2 TF Hours Oct. 24, 1930 Arkansas 516-34-3102 68 Director Usual Rasidence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or liams 23a or 28a-f show oficial Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Streef and Number 1000 Beechwood Avenue 21122 U.S.A. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, 11. Merifel Stetus Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 Widowed 4 □ Divorced Hygiene. other then "natura ent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Teller Banking permit. Pages 1 and 2 should be Illed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event. I 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Russell Stephenson Betty Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) Janet Hefler / daughter 622 Kensington Avenue, Severna Park, MD 21146 20b. Place of Disposition (Nema of cemetery, crematory or other place) 20a. Mathod of Disposition Feb. 15 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1999 Baltimore, MD 22. Name and Address of Facility
Barranco & Sons P.A., 21. Signaturo Funeral Service Licenta Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23e. Pert1. Enter the lisease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical Intercomial humorrhan Examiner Examiner The law requires that the death certificate be executed ettending physician end for use es the bunel-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown anti coasulation h 24b. Were autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? atrial Librillation Is certificate hes director, pege 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case raferred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred 5 Pending investigation 1 Datatural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be dataminad 3 Suicide 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Spacify) 28f. Location (Street and Numbar or Rural Routa Number, City or Town, State) 4 Homicida to Certifying Physician: To the best of my knowledge, death occurred at the fime, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical 29d. Defe signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier. MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene 32. P.gistrar's Signature State Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** FEB. 13 1999 0700 CATHERINE T. RICHARDSON /Medical 4b. City, Town, or Location of Death 4e Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Yaer | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 6 Sax **Funeral** Months Deys 1 M 2 F 215-12-8173 Yrs. 1917 MARYLAND Director JUNE 2 Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits show 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at BALTIMORE NONE 1 Tyras 2 No BALTIMORE Directo MARYLAND 10f. Zip Coda 10g. Citizen of What Country? 501 ALTER AVENUE 21208 IIS Funeral death 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑No If Yes, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican indian 11. Marital Status Black, White, atc. 1 Navar Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: BLACK þ 3 □Widowed 4 □ Divorced Completed 16a. Decedani's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Spacify only highast grada complated) Hygiene. Elementery/Secondery (0-12) Collega (1-4or 5+) 6th ARUNDEL LAUNDRY presser permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If frem 27 is marked othe any injury or other traumatic event, page. 18 Mother's Neme (First Middle Maiden Sumama) 17. Felher's Name (First, Middle, Last) Be (unknown) BOWIE DOWNS IDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) BETTY A. SIMMONS (SISTER) 1027 MADISON COURT ANNAPOLIS, MD. 21403 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition 1 Burial 2 Cremation 3 Ramoval from State 4 □ Donetion 5 □ Othar (Specify) 2/17/99 CROWNSVILLE, MARYLAND VETERAN CEME. 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility WM. REESE & SONS MORTUARY, P.A. Harry J. Leas 821 WFST ST. ANNAPOLIS, MD. 21401

23a. Pert1. Enter the disaasa, or complications that causad the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, interval Batween Onset and Death

Onset and Death **Physiclan** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Colon Concer Examiner Examiner physicien and the buriel-transit Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Ceusa (Diseesa or injury that initiated evants rasulting in daath) Last Dua to (or es a consequence of): Division of Vital Records, P.O. Box 68760, certificate be Physician/Medical Due to (or es e consequenca of): SE use a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 20hknown 1 Yes 2 No signed t þ 24b. Were autopsy findings evailabla prior to complation of cause of daath? Completed 24a. Was an autopsy performed? Road Failure page 2 s 1 Yas 2 → No 1 ☐ Yas 2 ☐ No certificate or Attending Physician: director, 25. Was casa rafarred to medical axaminar? 26. Place of Death (Chack only one) Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 25No inpatiant 2□ER/Outpatient 3□ DOA 2 this funeral 28a. Data of Injury (Month, Day Year) 27. Mennar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of Certification: Natural 5 Panding efter death. 1 Yas 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - Al homa, ferm, sfreef, factory, office building, atc. (Spacify) filled in by 4 Homicida Hospital 24 hours 29a. Cartifian Cortifying Physician: To tha best of my knowladga, daath occurred et the tima, dete end place, and dua to tha causa(s) and mannar es statad. Medical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner steted. (Check only one) within 2 the 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifier M3 03177 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) ROBCAT ALKN MILLACT MB Porkung 10 2143 32. Registrer's signatura

Registrar

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month **Physician** February 12 1999
4b. City, Town, or Location of Deeth 4c. County of Death 3:40 P.m Dorothy Margaret Reynolds 1999 /Medical 4a Facility Name (If not institution, give street and number) Examiner Glen Burnic Anne Arundel North Arundel Hospital | Worder 1 Year | Wunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr. 27, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2/1/F 82 Yrs. 181-50-4590 1916 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WXYes 2 No Directo Maryland Anne Arundel Severna Park 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? must be n 2400 Truckhouse Road 21146 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father'e Name (First, Middle, Last) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If Nem 27 is marked oth-any injury or other traumatic even å Alexander Beveridge Helen Busman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gay E. Corak/ Daughter 955 Forest Drive Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Burial ② Cremation 3 ☐ Removel from State Metropolitan Crematory 2-13-99 Alexandria, Virginia 4 Donation 5 Other (Specify) 22 Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Pert1. Enter in shock, or hear disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, tailure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner hysicien end the burisi-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): . Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown be det à 24b. Were autopsy findings evailable prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 212 No 1 Yes 2 No certificate 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpetient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Aftar 5 Pending Natural 1 Yes 2 No 2 Accident investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Box 68760. P.O. Division of Vital Records.

Dorothy

Seynolds,

altimore, Maryland

or Attanding Physician: sftar daeth. Director: Af To the Hospital or Atta-within 24 hours star day To the Funeral Directo complataly filled in by th

Registrar

Medical

29a, Certifier

(Check only one)

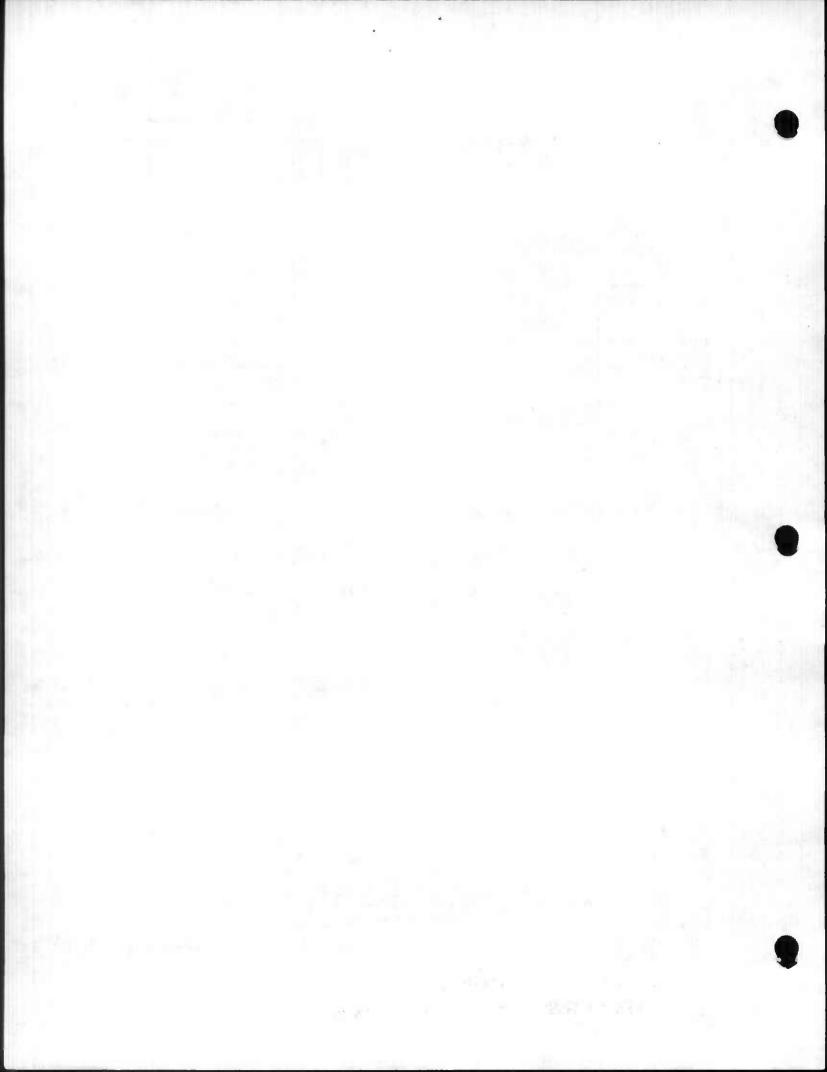
29b. Signature and title of contillor

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29c. License number

15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1:25 P. M. **Physician** Martin Rice James Ebruary 15 /Medical 4c. County of Death 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** GLEN BURNIE ANNE ARUNDEL ARUNDEL HOSPITAL Hours Min. 8. Date of Birth (Month, Day, Ye Jan 18, 1 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 15 M 2□ F Maryland 216-12-0669 Yrs. 102 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Severna Park Anne Arundel 1 Yes 2 No Director or 288-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21146 USA 378 South Drive 238 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 XYes 2 No If Yes, Give WWI Yeer or Detes: 1 Never Merried 2 Married Specify: White 8 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Local Union Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be next of Health and Mental Jessie Rice Mary Hemling 19e. Intorment's Neme/Reletionship, (Type, Print) Margaret Arnold / niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 Smith Avenue, Landsdowne, MD 21227 . important: If item 27 any injury or other to 20c. Location - City or Town, State 20b Place of Disposition (Name of 20e. Method of Disposition MD Veterans Cemetery Feb 19 1 Buriel 2 □ Cremetion 3 □ Removal from Stete Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 1999 21. Signature of Funeral 22 Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 sv. 23a. Perit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediete Cause (Final 3 days DNEHWONIA diseese or condition resulting in deeth) **Examiner** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician s the burial Physician/Medical Due to (or es a consequence of): 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown signed I þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No death. Investigetion 2 ☐ Accident 24 hours after dea Funeral Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 3 4 Homicide Hospital edical 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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P.O.

Records,

Division of Vital

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31. Date Ned (Month, Day, Year) FEB 1 8 1999 Registrar

29b. Signeture end title of certitier

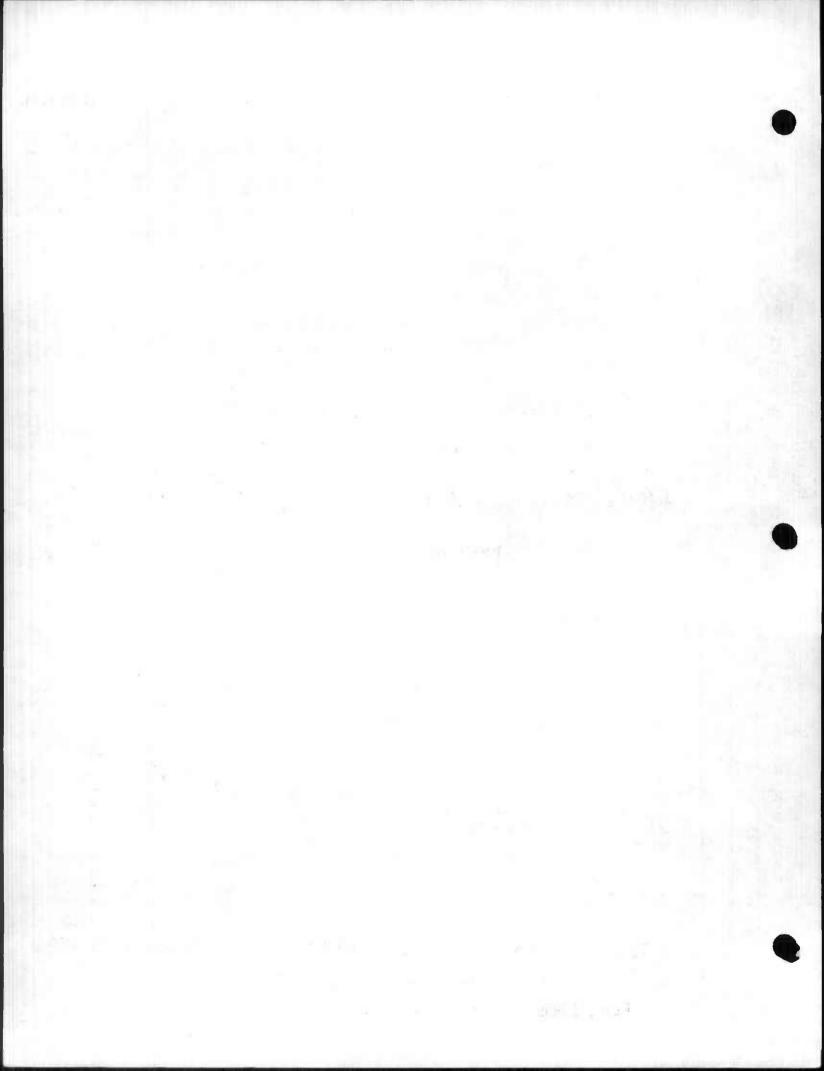
01 Hrzantul. 32. Registrar's Signature Dawe 301

30. Name and alidress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

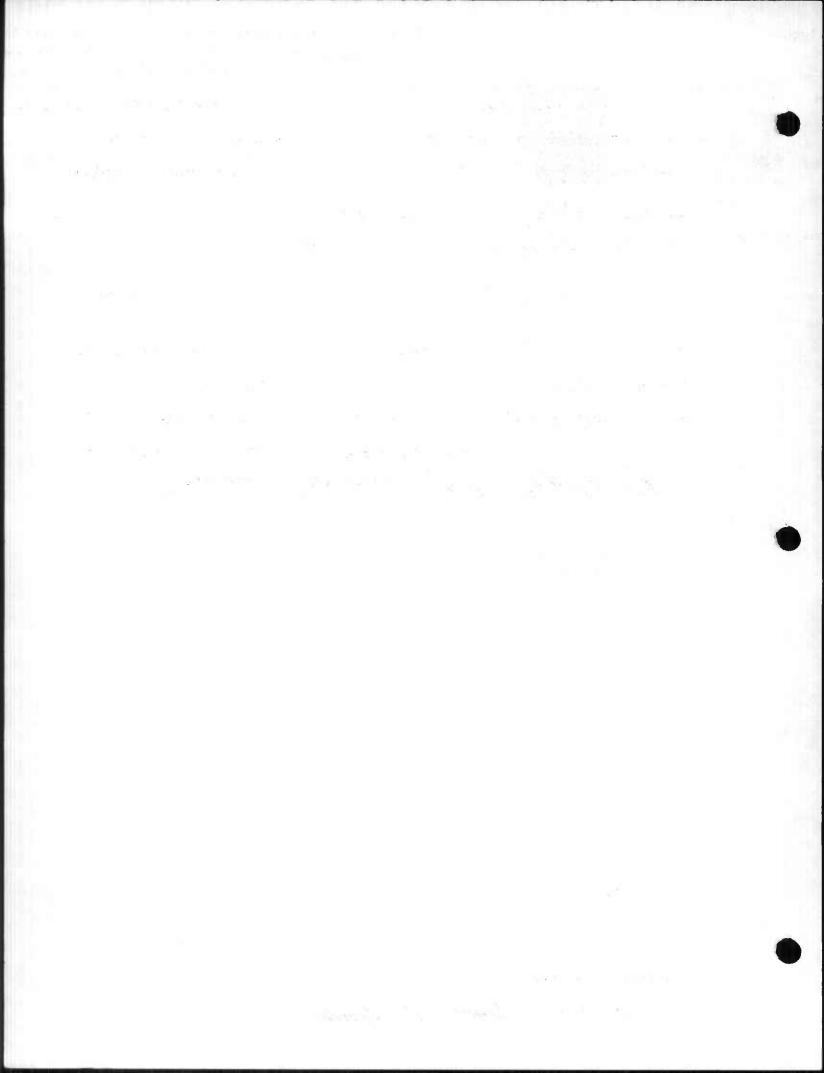
29d, Date signed (Month, Day, Year)

Buzzie. ms. 21061



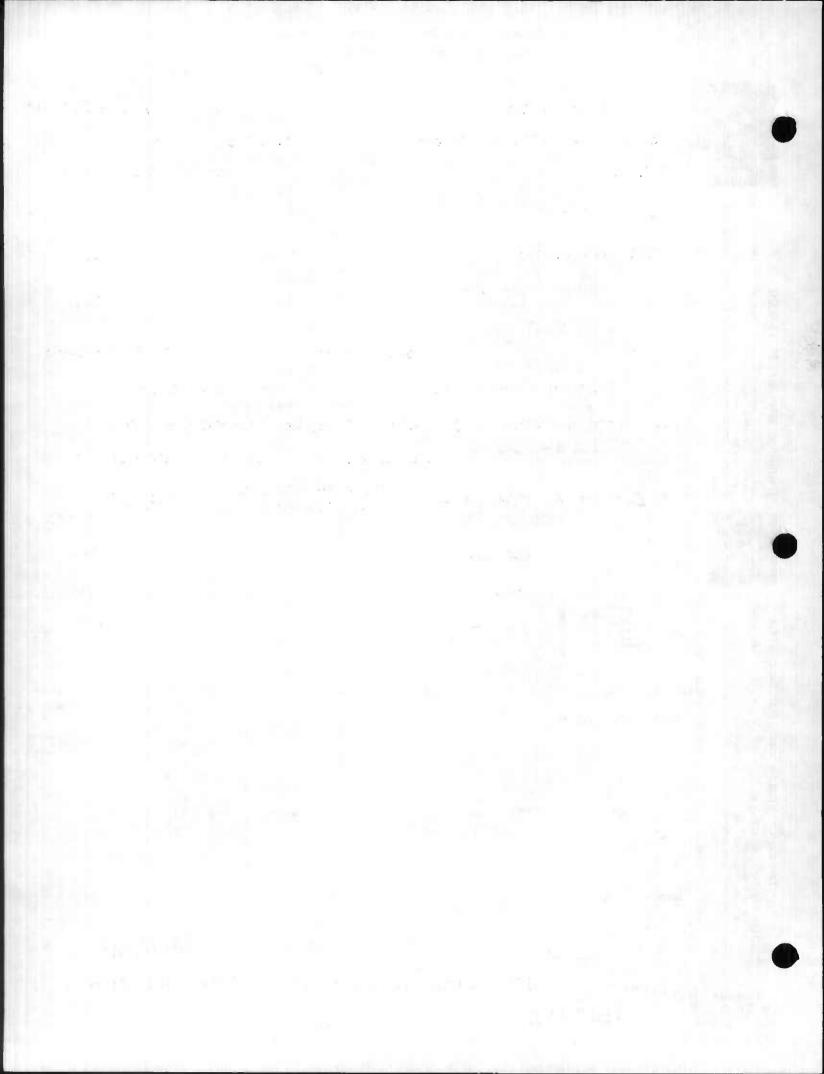
State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate d	of Death	,	Reg. No.	n 7	096		
	Diam'r.		1. Decedent's Nema (First, Middle, Last)				2. Data of De Month	eth		3. Tima of Death		
4	Physic /Medi		Frances 1	R. Sterling	3			Februar	y 19, 1	999	10:05 p.m		
1	Exami		4a. Facility Name (If not institution, giva				4b. City, Town, or		4c. County	of Death			
		ш	Edw.W.McCready Me				Crisf		Somerset				
	Funeral Director		215-05-4417	x	last birthday) Yrs.	Months De			th y, Year) 1919	9. Birthplace Country) Maryl	e (Stete or Foreign Land		
	pue *	ctor	Usual Residence of Decedant 10a. Steta 10b. County	10g, Cit	y, Town or L	ocation			10d. inside City Lin				
	Se-f sho		Maryland Somerse	et	Cr	isfield					1 ☐ Yas 20 No		
	23a or 2	rai Dire	10e. Street and Number 27012 Johnson Cree	ek Road		10f. Zip Cod	21817						
Maryland 21215-0020	72 hours efter deeth with the Meryland natural; or items 23s or 28s-f show diest Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Merried 2 □ Merried 3 ☑ Widowed 4 □ Divorced	12. Was Decedant Evar in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Detes:	,S. 13.	Wes Decedent If Yes, specify 0 1 ☐ Yas 2 2 1	of Hispanic Origin? (Suben, Maxican, Puer No Specity:			Rece - Amarican Indian, Black, Whita, etc. City: White			
5-0	72 h matu dissal	Completed	15. Decedant's Edu (Spacify only highast grad	16a. Dece (Give	edent's Usuel Oc e kind of work do	cupetion ne during most of wo tired)	orking	16b. Kind of Business/Industry					
121	Althin ne .	Idm	Elementery/Secondery (0-12)	College (1-4or 5+)			tired)						
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and	ntal h	9 Be		_						10)			
7	d Me d Me mark	10	Clarence C. Riggin 19e. informent's Name/Reletionship (Ty		10h Maili	Mildred L. Ward 9b. Meiling Address (Street and Number or Rural Routa Number, City or To					State Zin Code)		
Ma	d 2 s ith en 17 is 17 is		W. Terry Sterling				on Creek 1				21817		
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic avent, tra Medical Exa ance.		20e. Method of Disposition 120 Burlel 2 Cremation 3 F 4 Donetion 5 Other (Specify)	20b. Freemovel from State	Plece of Disponentery, cre	osition (Name or matory or other Memorial	plece)	Dete 2/23/99	20c. Location -		Stata		
Baltii	Departm Importan any injur		21. Signature Ponefal Service License	ged laur	/ B	2. Neme and Ad radshaw	dress of Fecility & Sons Fi	uneral He	ome				
			Robert H. Bro 23a. Part1. Enter the disease, or compl shock, or heert feilure. List only or	adshaw, Jr			ain St (-	21817	proxi <i>m</i> ate		
o,	Physician /Medical Examiner bhasician end streep physician end streep the physician end streep the physician end streep the physician control of t	Examiner	Immediate Cause (Finel disaesa or condition rasulting in deeth) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (or es a consequence of): Chole Cy Shits Due to (or es e consequence of):							aset end Deeth		
Box 68760,	ing e	Completed by Physician/Medical	resulting in deeth) Lest	Due to (o	r es e consec	quance of):							
	the att		Pert il. Other significent conditions cor	ntributing to death but not res	ulting in the u	underlying ceuse	23b. Did tobacco use contribute to the ceuse of deat						
S, P.O	es that the death ce igned by the attend be deteched for us		Acute	Renal Fa	ilme			10	Yas 20 No	3 Probabl	ly 4 ☐ Unknown		
Records,	e law require hes been sig ge 2 should b								an autopsy med?	eveilet	eutopsy findings ble prior to etion of cause th?		
	Page 1							10	res 2 No	1 □ Ya	as 2 No		
Vita	ysician: The l s certificate he director, page	Be	25. Was cese referred to medical exeminer?	loonited.		T		eth (Check only o	one)				
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	the free free free free free free free fr	tion:	27. Menner of Deeth 1 Neturel 5 Pending	28a. Dete of injury (Month, Dey Year)	28b. Time of Injury	1	njury et Work? I ☐ Yes 2 ☐ No	28d. Describe how Injury occur		rred			
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specify	ome, farm, st				n (Street end Number or Rural Routa Number, Town, Stete)				
	To the Hospital or A within 24 hours effer To the Funeral Direc completely filled in b	edical	29a. Certifier (Check only one) Certifying Phys	aiclan: To the best of my knowner: On the basis of examinal end manner stated.	wledge, deat tion end/or in	h occurred et the	e time, dete end plec ly opinion, deeth occ	e, end due to the urred et the time,	the cause(s) and manner as steted. ne, dete end piece, and due to the ceuse(s)				
	To th Withir To th	Me	29b. Signeture end title of certifier			29c. Lic	ense nu <i>m</i> ber		29d. Dete signed (Month, Dey, Year)				
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			30. Neme end eddress of person who co Dr. Vijay Karumbur				Crisfield,	Md. 218	317				
	Sta	ite	31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signa	ture	- /							



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Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth Dey **Physician** 430 AM Squires Elsie Evelyn February 17, 199
on of Deeth 4c. County of Deeth 1999 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) Examiner St. Agnes Rehabilitation Center Ellicott City If Under 1 Year 8. Data of Birth (Month, Day, Yeer) June 22, 5. Social Security Number 7. Age (In yrs. last birthday) If Undar 24 Hrs. Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 1 □ M 2 TF 216-03-6714 83 Yrs. 1915 Maryland **Director** Usual Residence of Decedent the Maryland r 28a-f ahow a notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Sykesville 1 ☐ Yas 🏋 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with r than "natural", or items 23s or the Wouldal Examiner must be r 13717 Barberry Way 21784 U.S.A. death Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 1 No If Yes, Give Yaar or Datas: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after Department of Health end Mentel Hygiene. Important: if item 27 is merked other than "natural", or iten any injury or other traumetic event, the Mourcal Examine 0059. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ White 3 Widowad 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 US Postal Service Postmistress 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fethar's Neme (First, Middle, Last) Be Sylvanus Clinton Hunley Cora Belle Bargar 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Brenton H. Squires (son) 13717 Barberry Way Sykesville, MD 21784 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition Dete 1 XBurial 2 Cremetion 3 Removal from State Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Woodlawn Cemetery 2/20/99 21. Signatura of Funeral Service Licensae 22. Name end Address of Fecility HAIGHT FUNERAL HOME & CHAPEL (Box 195) 23e. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Haig Approximete fntervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Dua to (or es a consequence of): Examiner iclen end burial-transit death certificate be executed Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Dua to (or as a consequence of): · Permentio Division of Vital Records, P.O. Box 68760, attending physiclen for use as the buris Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Assonunge MASS signed t by 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? Completed 24a. Was an eutopsy certificate has b director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 250No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Day Year) funerel 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 Naturel 5 ☐ Pending after deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) à a Euneral Direction of Funeral 4 Homlcide Hospital 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical completely (Check only one) within 2 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signeture end my of certifier 4868suprecus 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Columbos, My DIGIZA 11022 Umi PATURENT 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture FEB 2 2 1999 Tenera Registrar



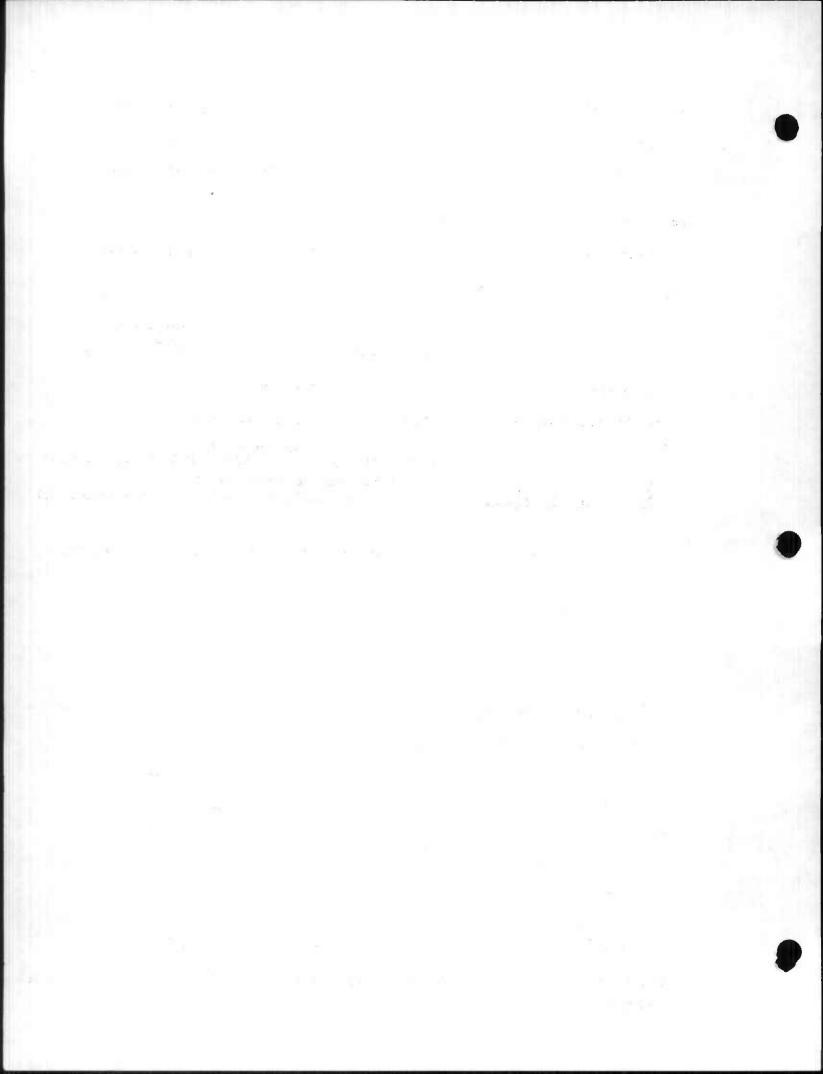
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month Physician Irma Ruth Spence 1615 February 19, 1999 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 564 Middle Road Cecil Elkton If Under 24 Hrs. 8. Dete of Birth (Month, Day, January 19, 5. Social Sacurity Number If Under 1 6. Sex 7. Aga (In yrs, lest birthday) 9. Birthpleca (Stete or Foraign **Funeral** Year) 1923 Virginia Deys 1 □ M 2 XF Months Yrs 76 Director 218-22-6485 Usual Residence of Decedent the Maryland 10e. Stete 10b. County show 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 TNo Director Maryland Cecil Elkton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 564 Middle Road 21921 United States Funerai death Herns ; 11 Marital Status 12. Wes Decedant Ever In U.S. Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Race - American Indien Armed Forces?

1 Yas 2 XNo
If Yes, Give
Year or Dates: The Medical Examiner Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 6 White 1 Tyes 2 No Specify: Completed by 3 Widowed 4 □ Divorced natural'. 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland State I Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Highway 12 Supervisor Administration trsumetic event, Maryland 17. Fether's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Meiden Sumeme) is marked of Pages 1 end 2 should be Susan Hurst Isacc Rigney 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) nt of Health e P.O. Box 587, Rising Sun, Maryland 21911 Donna Jourdan/ Daughter other 1 Baltimore, 20b. Piece of Disposition (Name of cematery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State February 23 1 Burial 2 □ Cremetion 3 □ Removel from Stete 0 Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Fair Hill, Maryland Sharps Cemetery 21. Signature of Funerei Service Licensee 22 Name and Address of Facility Tunerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 eles) 23a. Pert1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final Prubable Acute MOCARDIAL INFARCTION 3 TAIGS MI disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of): The lew requires that the death certificate be executed Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): Box 68760, ettending physician Physician/Medical the Due to (or es a consequence of): use as P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. detached the 23b. Did tobacco use contribute to the cause of death? signed by DILATED CARTADINGOPATHY 1 | Yee 2 | No 3 | Probably 4 | Onknown Records, þ 8 24b. Were eutopsy findings available prior to completion of causa of deeth? Completed 24e. Wes en eutopsy performed? ATRIAL FIBRILLATION peen page 2 this certificate 1 ☐ Yes 2 ☐ 110 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director Be 25. Wes cese referred to medicel exeminer? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral Certification: 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Naturel 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) or A efter 4 - Homicide To the Hospital within 24 hours of To the Funeral Completely filled Hospital 24 hours e 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as steled.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the ceusa(s) end menner steled. 29e. Certifier Medicai 29b. Signature and title of certification 29c. Licansa number 29d. Deta signad (Month, Day, Year) 44102 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) WARRUPTON B) ELKTON ND 2921

State Registrar WILLIAM

RENZUM 22. Registrer's Signature

MID



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 5mith MAE EBRUARY 12 8:00 AM 1999 4e. Fecility Nema (If not Institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death MANOR- HEALTH R 15 IN C- SUN
If Undar 24 Hrs.
Hours Min.
B. Data of Bird.
(Month, Da CECIL CENTER If Under 1 Year 9. Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 1□M 2**X**F 181-05-7374 APRIL 19, 1914 Usual Rasidanca of Dacadant 10b. County 10c. City, Town or Location 10d. Inside City Limita CECIL 1 ☐ Yas 2 No RISING SUN MD. 10e. Straat and Number 10f. Zip Code 10g. Citizan of What Country? 981 TELEURAPH RD. 1.5.A. 1911 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Raca - American Indian, Black, Whita, atc. 11 Maritai Status Yas 2 No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Marriad 1 Yas 2 No 3 ₩ Widowad 4 Divorcad WHITE 16e. Decedant's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Spacify only highest grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SPERVIUE POSTAL EMPLOYER UNKNOWN UNKNOWN 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) CAZIER MAE TRAINOR CAMERON 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Pa. 19363 NIECE 4 SUMMITT AVE. OXFORD ANN BILBY 20b. Placa of Disposition (Nama of comatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta Data 1 Burial 2 □ Cramation 3 □ Removel from Stata OXFORD CEMPTERM 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licansea 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Vist only one ceuse on each line. HOME 259 E. MAIN ST. ELATON Immediata Causa (Final disaase or condition rasulting in death) Congestive PulmonARY Dis, Sequentially list conditions, if eny, laading to immadiate causa. Entar Underlying Causa (Disaasa or Injury that initiatad avants rasulting in death) Last ARTERIOSCIEROTIC Due to (or es a consequance of): ARDIO RENAL DISCASE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ninknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? 26. Pleca of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 1 Yas 2 No

1 Yas

Examiner Box 68760, Division of Vital Records,

or Attending after death Director:

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral', or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours attar Department of Health end Mental Hygiona. Important: If Itam 27 is marked other than "natural", or its any injury or other traumatic event, the Medical Exercises.

Physician

/Medical

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

2

Physician/Medical Examiner

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Completed

Certification: To

27. Mannar of Daath

Netural

2 Accident

3 Suicida

29a. Certifier

4 | Homicide

(Check only one)

within 24 hours a

After this

the

death.

To the Hospitai

State Registrar

29b. Signature and title of certifier 30. Nama and addrass of person who completed cause of deeth (Item 23e) (Type, Print) Phillips MAlcolm , M.D. 31. Date filad (Month, Dey, Year)

5 Panding Invastigation

6 Could not be detarmined

9 1999

1 Cartifying Phyaician: To the best of my knowladga, daath occurred at tha tima, date end plece, and due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred et the time, date and placa, end due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year)

MASONIC Building, DARlingTON, MD. 21034

28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

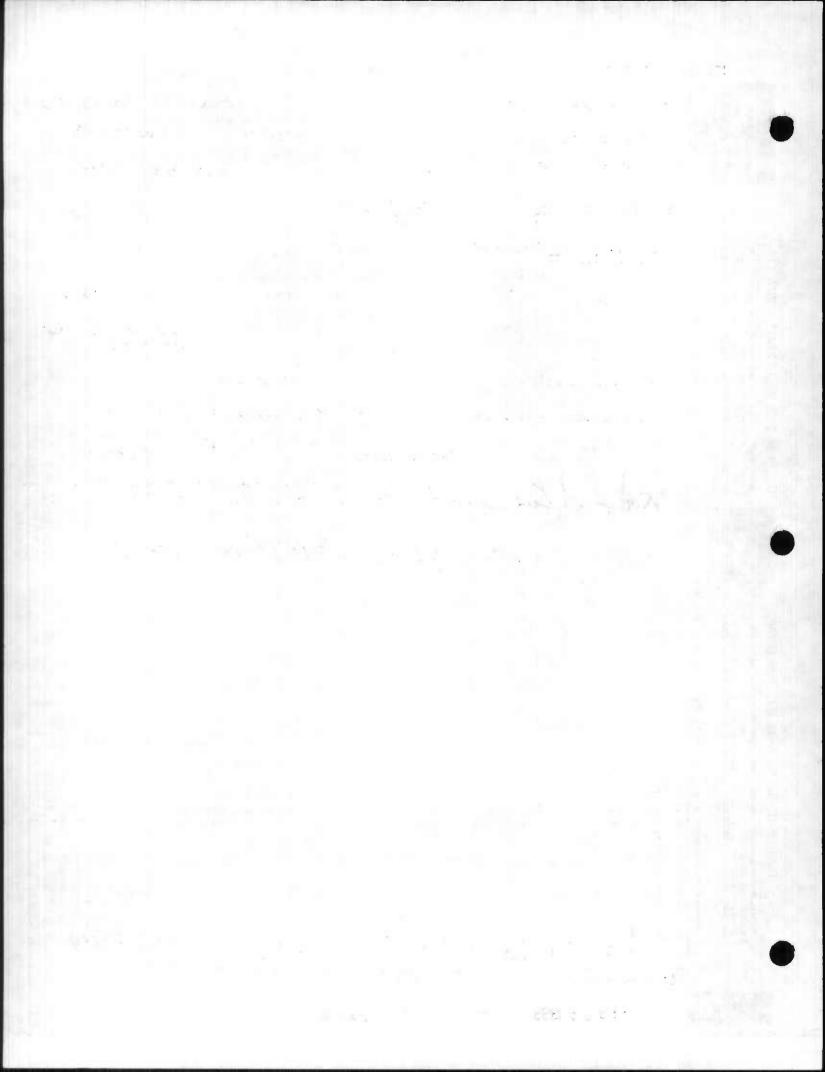
32. Ragistrar's Signatura

28b. Time of

28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

1. Decedent's	Nama (First, Middle	, Last)					71.74	2. Date	of Death	. No.	Year	3. Tima of Death
Jonath	Jonathan Cass Stimson 4a Facility Nama (If not institution, give street and number)						4h Cih. Tau	Febr			1999 1	0:55 am
	ma (17 not institution, napolitan	, give street an	na number)				Annap		4c. County of Death Anne Arundel			el
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10a. State	10b. County			10c, City,	Town or Local	tion C					10d	. Inside City Limit
Wash D	ANNE ARU	NDEL,			APOLIS	117 1/c						100 Yes 200 N
725 24th Street N.W. #210 200:						10f. Zip Code 20037	21401			10g. Citizen of What Country? USA		
1 Never Married 2 Married 1 Name of the lift Years of the lift Yea			Decedent End Forces? Yes 2 □ Notes, Give or or Detes:	es 2□No Give 1□Yas 2ÅN			Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.) Specify:			o- 14. Race - American Indian, Black, White, etc. Specify: White		
(Specify only highest grade completed) (Give I Elementary/Secondary (0-12) College (1-4or 5+)					(Give kin life. DO	lent's Usuel Occupation kind of work done during most of working O NOT use retired)			C	16b. Kind of Business/Industry Chicago Sanitation Department		
17. Fathar's Name (First, Middle, Last) Jonathan C. Stimson						18. Mother's Name (First, Middle, Malden Sumame) Viola Hartz						
19a. Informant'a Na <i>me</i> /Relationship (<i>Type</i> , <i>Print</i>) Richard Stimson / brother 19b. Malling Address (<i>Street</i> and <i>Number</i> or <i>Rural Route Number</i> , <i>City</i> or <i>Town</i> , <i>State</i> , <i>Zij</i> 24 Sunset Drive, Severna Park, MD 21146								ode)				
	of Disposition 1 2 Caremation tion 5 Other (Sp		from Steta	cen	ca of Disposition etery, cremeter Creme	tory or other ple	ece)	Feb 1999	5		ore, M	
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DHMH 16 Rsv 6/95



The law requires that the death certificate be executed Box 68760. P.O. Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** FEBRUARY 4:36PM EARME A. SPRIGGS /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BUENIE AA COUNTY ARUNDEL GIEN NORTH HOSPITAL 5. Social Security Number 217-24-4700 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 10 M 25 F Yrs Director 27 1927 MARYLAND JUNE Usuet Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits MARYLAND ANNE ARUNDEL Nes 2□No SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? à 7845 CLARK STATION ROAD 21144 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 20 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: BLACK by 3) Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th La CONTINENTAL COOK 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important; if Nem 27 is marked out any Injury or other traumatic avar pages. Be Pages 1 and 2 should be Health and Mental WILSON CHISLEY MARGUERITE CHISLEY 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BARBARA SPRIGGS (DAUGHTER) 7845 CLARK STATION RD. SEVERN, MD. 21144 20b. Place of Disposition (Neme of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place) *DBurial 2 Cremation 3 Removel from State MARYLAND VETERAN CEME. 4 ☐ Donation 5 ☐ Other (Specify) 2/18/99 CROWNSVILLE, MD. 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A. elsa 821 WEST ST ANNAPOLIS 21401 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): been signed by the a should be detached Pert II. Other algorificant conditions contributing to death but not resulting In the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 10 3 Probably 4 Unknown 1 Yes by Completed 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of deeth? page 2 20 No 2/2 No Division of Vital or Attending Physician; 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death
1 Natural
2 Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation death. 1☐ Yes 2☐ No after death 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide filled in Hospital within 24 hours of To the Funeral I completely filled To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated.

On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) å 29b. Signeture and title of our 29c. License number 29d. Date signed (Month, Dey, Year) 2 cause of death (Item 23a) (Type, Print) 30. Name and addre CISV BURNE EPAR m.6 State 1999 Registrar

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

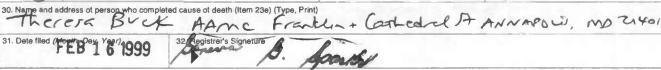
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Physician 1999 Sarah Bonavere Sweezy Feb. 11 6:32 PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Annapolis

If Under 24 Hrs.
Hours Min.

Min.
April 24, 1923 Anne Arundel Medical Center Anne Arundel If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 □ M 2 1 F Months 75 Yrs. 165-20-7541 West Virginia **Director** Usuel Residence of Decedent the Menylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Md. Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 1365 Almond Drive 21401 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mantal Hygiane. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Event Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Maryland 21215-0020 1 Yes 2 No Specify: Specify: g 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) Dept. Store Salon Receptionist 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Sleetie River Wiseman Bernard Baxter Herron 2 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Marvin Dwight Sweezy / son 501 East Pearl St. Burlington , N.J. 08016 altimore, 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2-12-99 Ft. Lincoln Crematory Brentwood, Md. 22. Name end Address of Fecility John M. Taylor Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Part 1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellure. List only one cause on each line. Approximate tntervel Between Onset and Deeth Physician Immediate Cause (Finei diseese or condition resulting in death) /Medical Intracerebral Examiner Due to (or es e consequenca ot): Examiner 2000 physician end the burial-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest Due to (or es e consequenca of): Box 68760 Physician/Medical Due to (or es e consequence of): 80 USB Po 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably Unknown Division of Vital Records, by 8 24b. Were eutopsy tindings eveileble prior to should 24e. Wes en eutopsy performed? Completed completion of cause of death? has page 2 2 WNO 1□ Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No t impatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of Naturel 2 Accident 5 Pending aftar death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pieca of Injury - At home, farm, street, tectory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral D Hospital 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end menner es stated. Medical (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. within 2

State Registrar

29b. Signatura ar



USICAN

29c. License number

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29d. Dete signed (Month, Day, Year)

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99-1137-001 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ihm State of Maryland / Department of Health and Mental Hygiene () CYNTHIA KAY ITEMS: #23 PART I, 27 PER MEO G769 3-31-99 Certificate of Death STECMATER 1. Decedent's Name (First, Middle, Last) 2 Data of Death 3 Time of Death Month Day Year FEBRUARY 26, 1999 **Physician** 09:22 AM CYNTHIA KAY STEGMAIER /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 12231 UPPER GEORGES CREEK ROAD ALLEGANY if Under 1 Yaar 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Days Min 1 □ M 2 X F Months Hours Yrs Director 218-80-5365 Oct 21. MD Usual Residence of Deceden the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumetic avent, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo MD Frostburg Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23₽ 12231 Upper Georges Creek Road 21532 Funeral USA death Hems ? 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian Black, Whita, atc. permit. Pagas 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena.

Important: If Item 27 is marked nether any injury or other services. 1 Yes W No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be George Earl Boore Violet (Brobst) 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Michael Stegmaier-husband 12231 Upper Georges Creek Rd Frostburg, MD 21532 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory Cumberland, MD 03/02 22. Name and Address of Facility 21. Signature of Funeral Service Licensea Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Part1. Enter tha disaasa, or complications that ceused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each lina. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical FAT INFILTRATION OF RIGHT VENTRICLE Examiner Due to (or es e consequence of): Examiner physician and the burial-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequance of): use 10 signed by the at d be datached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed peen cartificate has 25. Wes case referred to medicel examiner? Be 26. Place of Death (Check only one) 1© Yes 2□ No Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. fnjury at Work? Certification: 5 Pending Investigation 1 Natural death. 1 Tyes 2 □ No 2 Accident after death Director: 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 completaly filled in Hospital 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

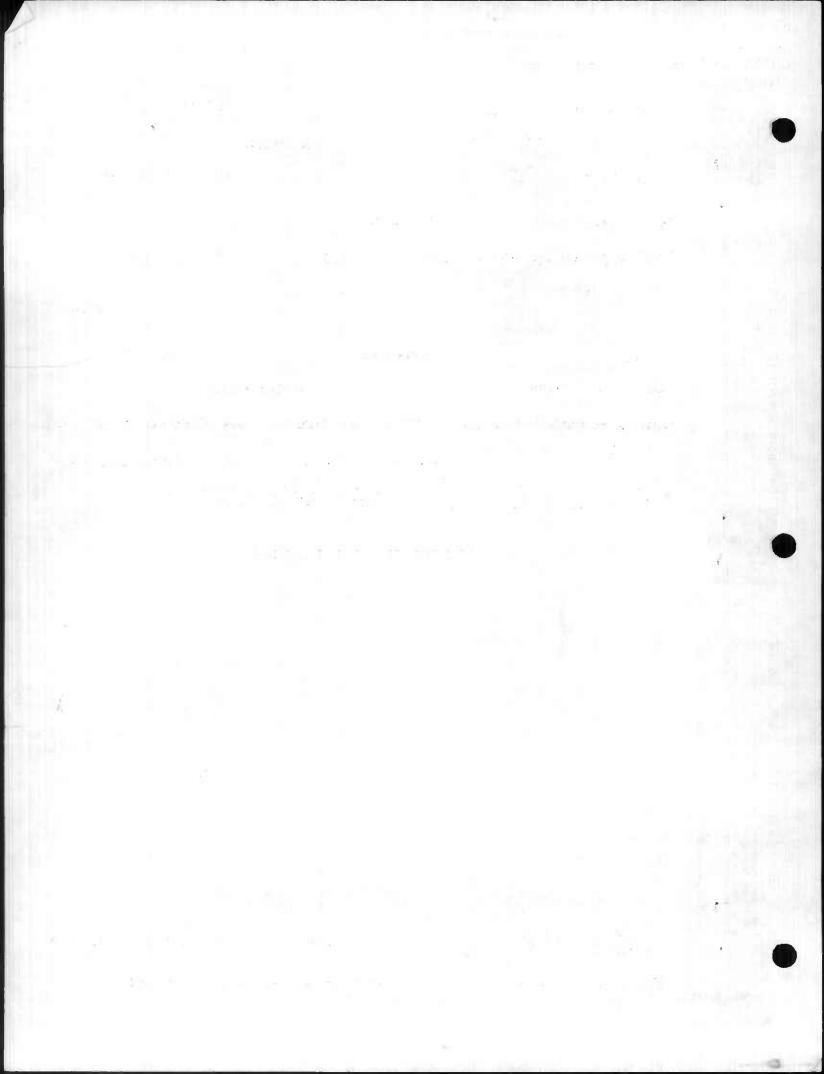
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) To the To the To the 29b. Signatura and titla of certified 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 27, 1999 OCME 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) THEODORE Penn Street, Baltimore, Maryland 21201 111 32. Registrar's Signeture

State Registrar

MAD

1999

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Deta of Daath 3. Tima of Deeth **Physician** Month 99 3:45 ain eagle trances 2 /Medical 4e. Facility Nama (If not institution, giva street end numbar) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** HQ 6. Sex POCOMOKE ar If Under 24 Hrs. S Hours Min. Hartley 5. Sociel Security Numbar 8. Data of Birth (Month, Day, Year) SING Worcester Home If Under 1 Yaar 7. Aga (In yrs. last birthday). Yrs. 9. Birthplaca (Stata or Foreign Country) **Funeral** Months Deys 05-8564 1□M 20 F Director -26-14 Usuat Rasidenca of Dacedant 10a. State 10b. County 10c. City, Town or Location permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28s-f show any injury or other traumetic event, the Moolcal Eventiner invest by notified as 10d. tnsida City Limits Director 1 XYas 2 No orcester Ocomoke 10f. Zip Coda 10g. Citizen of What Country? 2/51 13. Was Decedant of Hispanic Origin? (Specify Yes or Noff Yas, specify Cuban, Maxican, Puerto Rican, atc.) 502 BONNEU HUENUE LISIA 6 Completed by Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 11. Maritel Status 14. Race - Amarican Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Dates: 1 Navar Merriad 2 Married 1 ☐ Yas 2 No Spacify: 3 Widowad 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedant's Usuat Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 15. Decedant's Education (Spacify only highast grada complated) Elamentary/Secondary (0-12) College (1-4or 5+) arade 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) DINN Ella Collick Roymono 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rurel Routa Number, City or Town, Stata, Zip Coda) Stoudmire (daughter 502-Bonneville Pocomoke heresa VENUE md, 21851 J 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removel from State Pocomoke Md. 2-27-99 4 ☐ Donation 5 ☐ Othar (Specify) Shilon enetary 22. Nama and Addrass of Facility Bennic 21. Signatura of Funarai Service Licansee Smith Funcial Home 10, Box 331 Pocomoke City 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiec or respiratory errest, shock, or haert failure. List only one cause on each line. Physician /Medical Immediata Causa (Finel diseasa or condition Examiner Dua to (or as a consequence of) Sequantiatly list conditions, if any, leading to immediate causa. Enter Undarlying Causa (Disaesa or injury Due to (or as a consaquence of): Physician/Medical that initiated avents resulting in death) Last Dua to (or as e consaguance of): Pert tt. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 K No 3 Probably 4 Unknown ð 24b. Were eutopsy findings eveilebte prior to completion of causa of deeth? Completed 24a. Was an autopay Zout 1□ Yes 25 No 1 1 Ves 256 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a, Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 Naturat 1 Yes 2 Accident

buriel-tran pue Division of Vital Records, P.O. Box 68760. signed by the attending physician es the t use i Po 90 hes certificate the Hospital or Attending Physician: this : After this To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun

death with the Maryland

Baltimore, Maryland 21215-0020

Certification:

edicai

29a. Cartifier

(Check only one)

6 ☐ Could not be 3 ☐ Suicida 4 Homicida

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

12 Cartifying Phyalcian: To tha best of my knowladga, daath occurred at tha tima, dete end place, and dua to tha ceuse(s) end mannar as stated.

2 Medical Examiner: On tha basis of exeminetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and mannar stated. 29c. Licensa number 29d. Date signed (Month, Day, Yeer)

29b. Signeture and titla of certifier Dellows elgeri

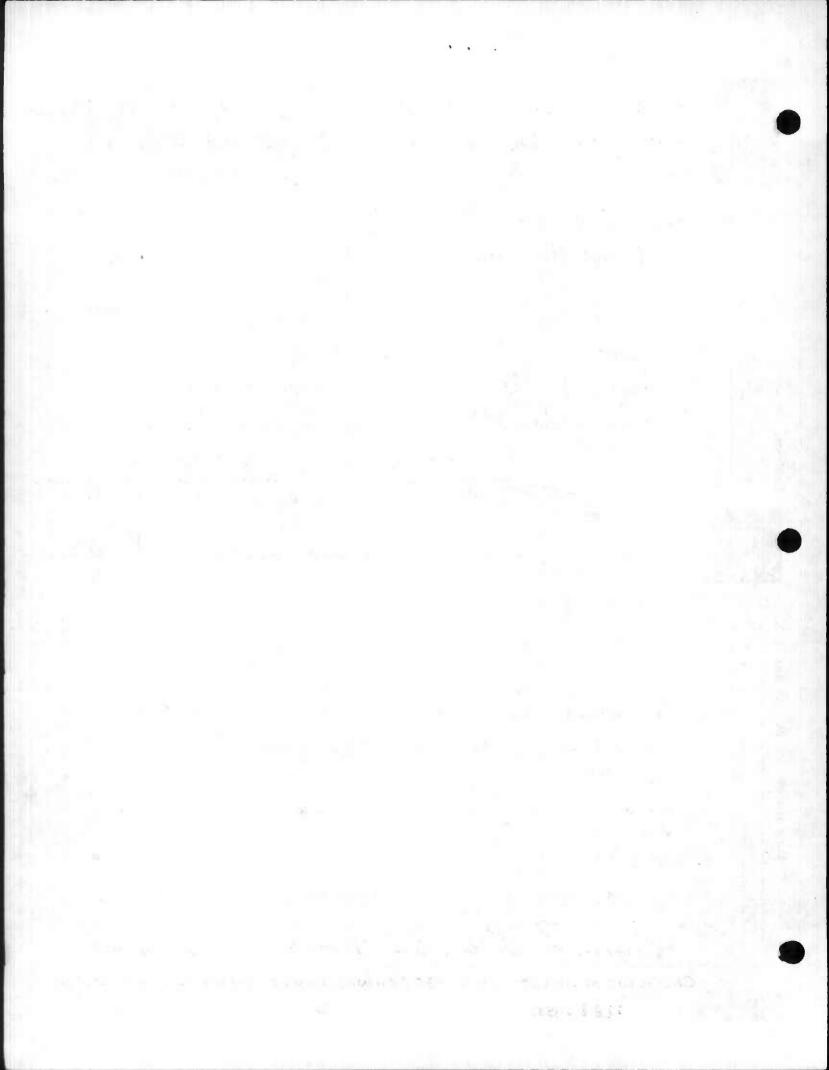
30 Nema and address of person who complated cause of deeth (Itam 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 31. Date filad (Month, Day, Yaar)

State Registrar

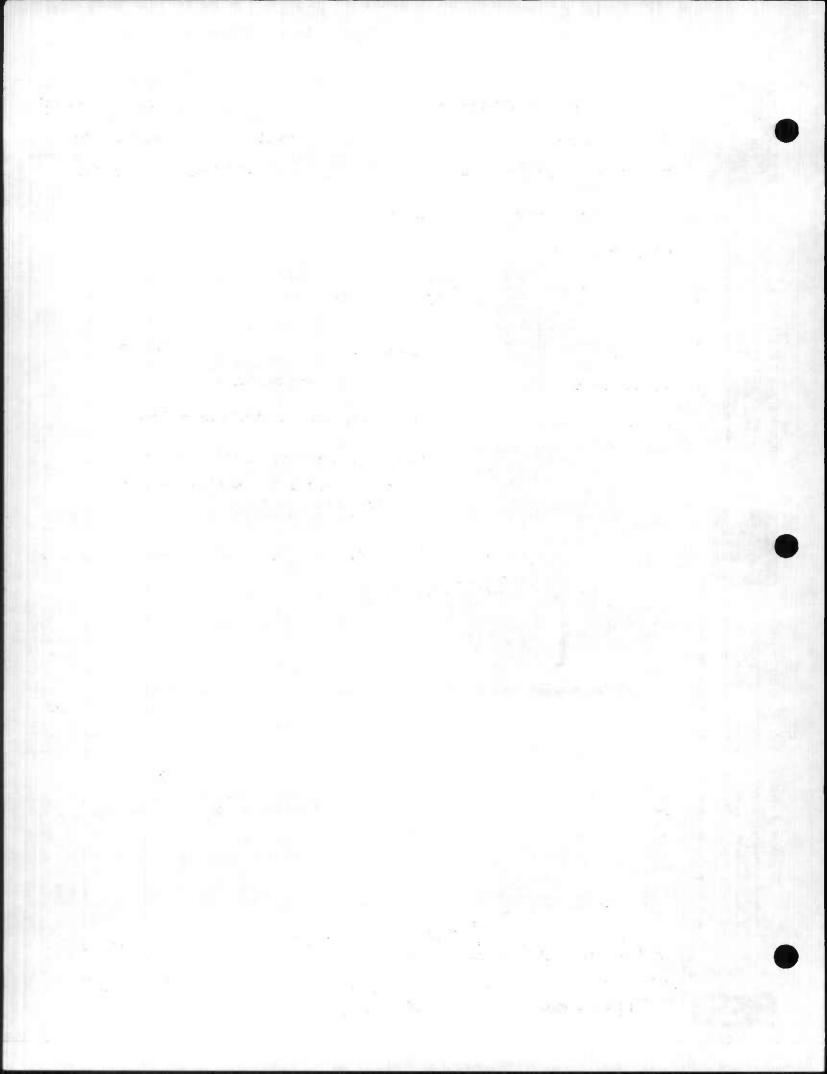
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32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 9 9 7 1 0 5

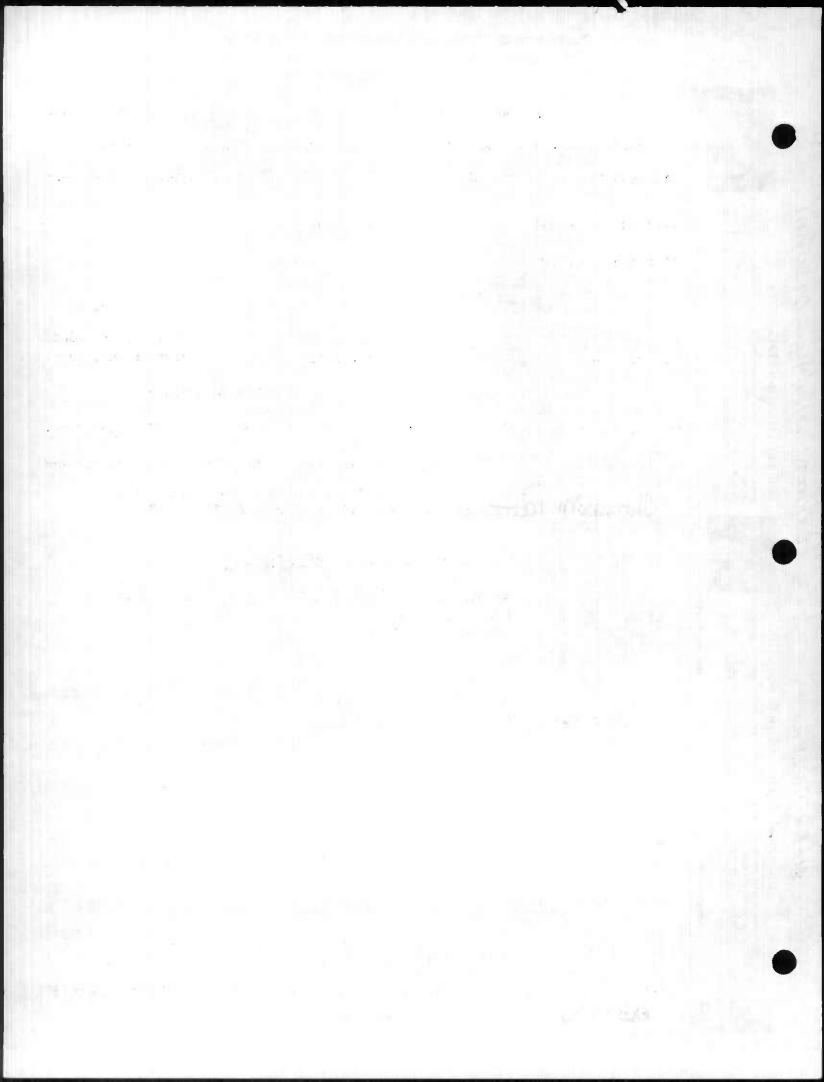
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permit. Page Department of Important: If any Injury or once.		re of Funarei Servic	-	Man	904-		22. Nama a	nd Addra	ss of Fecility	Cremat:					
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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 17, Month **Physician** 1999 0430 Hazel Ruby Viars February /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 10, 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2 F 82 Yrs 218-14-9644 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Marylar tem 27 le marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Cecil Port Deposit 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 165 Principio Road 21904 U.S.A. Funeral hours aftar death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: 2 White 3 Widowed 4 Divorced 'natural', 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) V.A. Medical Center end 2 should be filed within eelth and Mental Hygiene. II 27 le marked other than College (1-4or 5+) Elementary/Secondary (0-12) Twelve Years Perry Point, Maryland Nurse's Aid 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Thomas Hutchens Virgie Swisher 19a. fnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Heelth important: If Item 27 I John L. Viars (Husband) 165 Principio Road, Port Deposit, Maryland 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 NXBuriel 2 Cremetion 3 Removal from State 8 2/20/99 Rising Sun, Maryland Brookview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate fntervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last pue Physician/Medical Due to (or as a consequence of): the 98 esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 should After this certificata has 2 No 1 Yes 1 Yes 2 No 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1☐ Yes 2 1No NA 2 Accident NA aftar deeth 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted. Medicai (Check only one) 2 Medical Examinar: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steted. To the To the To the 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) Neau 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 10 BrIAN T. Yes South Union Avenue Havre de GRACE. MARY land 21078 801 32. Registrar's Signature State Registrar

xPieco

VIARS, HAZEL



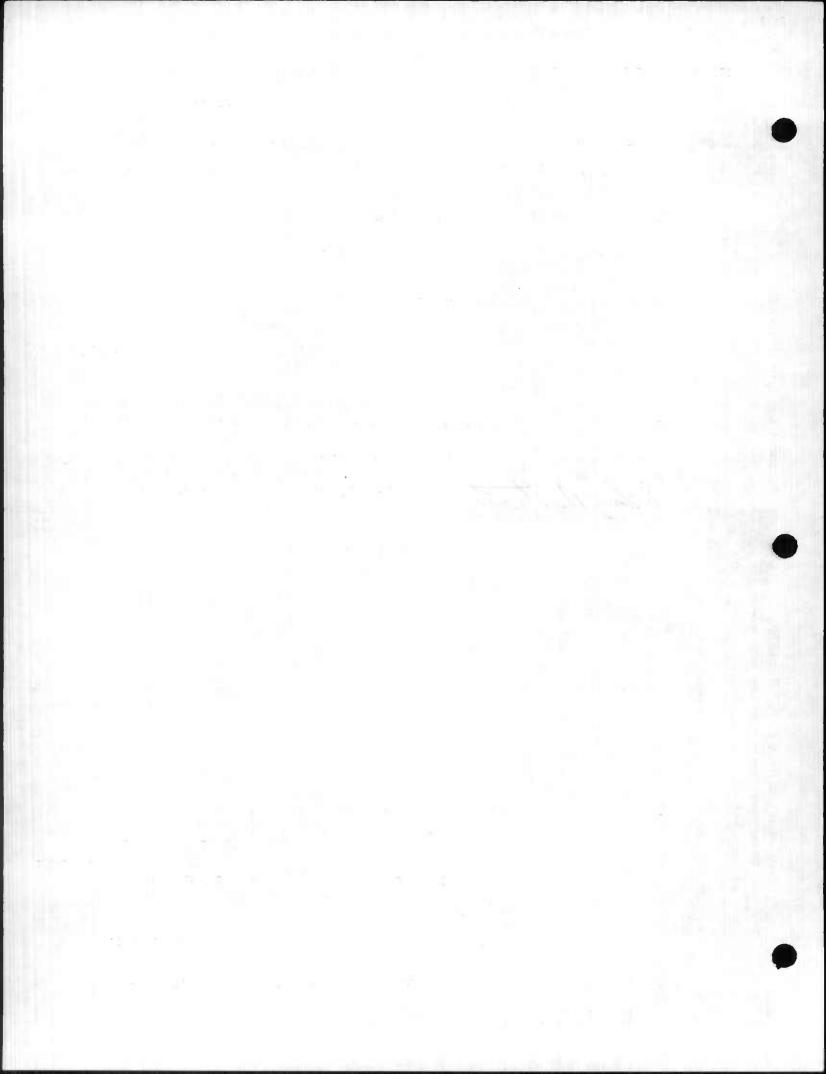
State of Maryland Department of Health and Mental Hygiene 9 ITEMS: #23 PART I, 27, 28A-F PER MEO G769 3-9-99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death FEBRUARY 27, 1999 **Physician** JACK AUSTIN WHITE 1.558 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner CITY BALTIMORE CITY
If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
6 / 3 0 / 1 9 5 2 UNIVERSITY HOSPITAL If Under 1 Yes 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** 1♥ M 2□ F 46 539-53-9967 Director COLORADO Usual Residence of Decedent filed within 72 hours efter death with the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ahow ahow Mes 2 No CARROLL WESTMINSTER MD. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 21157 202 E. MAIN ST. USA. Funeral "natural", or items 14. Race - American Indien, 12, Was Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 Widowed 4 Divorced Yeer or Dates: VIETNAM r than 'natur Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ith end Mental Hygiene. 27 is marked other than r traumatic event, tre Me Elementery/Secondery (0-12) College (1-4or 5+) CARPENTER CONSTRUCTION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Peges 1 and 2 should be inent of Heelth and Mental Int. If item 27 is marked or 20 UNKNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) KARYL LYNNE WHITE - WIFE 202 E. MAIN ST., WESTMINSTER, MD. 21157 ttem 2. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Peges Depertment of Important: If it any injury or o 1 ☐ Burlat 2 【Cremation 3 ☐ Removal from State METRO CREMATORY 3/3/99 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD. 22. Name end Address of Facility FLETCHER FUNERAL HOME 21. Signature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the dismase of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heaft failure. The only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** /Medicai Immediate Cause (Final HEAD INJURY disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician end s the buriel-trensit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 edicai Due to (or es e consequence of): ettending p for use es Physician/M signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? should 24a. Was an autopsy Completed performed is certificate hes t director, pege 2 s Phe Ph 1 Yes 2 □ No 18 Yes 2 No Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? 1X Yes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ₩Xnpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 10 this funeral 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred P After Found's 1 Natural 5 Pending s effer de... al Director: Afr 1 Yes 2 No 2-26-99 Investigation DECEDENT WAS ASSAULTED 2 Accident 3:45P 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number City or Town, State) 202 W. MAIN STREET 4 Homicide 6 To the Hospital or within 24 hours eft To the Funeral Di completely filled in NEAR RAILROAD TRACKS WESTMINSTER, MARYLAND Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) OCME FEBRUARY 28, 1999 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ville. lavia 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 1999

Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year ALFRED WOOLARD FeB 5, 1999 4c. County of Death 4a. Facility Name (If not Institution, giva streat and number) 4b. City, Town, or Location of Death If Under 1 Year If Under 24 Hrs. 8 CECIL SUNRISE Re HAB Are 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (Stata or Foreign Country) Days Yrs. 180-05-095 Usual Residence of Decedant Dec, 24,1969 10b. County 10c. City, Town or Location 10d. fnslde City Limits 1 Yes 2 No MA (JLAND) 10e. Street and Number CCI 10f. Zip Code 10g. Citizen of What Country? YOIN T 2504 0601 21921 U.S.A. 12. Was Decedant Evar in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Yes 2 No If Yas, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COURRIER BANKING 12 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Malden Surname) No INfo GILLINGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Ody or Town, State, Zip Code) Po Box 1159 20b. Place of Disposition (Nama of cemetery, crematory or other place) ELKTON MO. SANDIA 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State A. Fellis INC 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Meun Gee FUNCIAL Home 259 E. MAIN STELLONMO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseasa or condition resulting in death) PRECUMOHIA 26818 SENILE DEBILITY 1 YEAR Due to (or as a consequence of): DIKIBETES 1 YEAR MELLITUS Due to (or as a consequence of): 345MRS ANTENIO SCIENOTIC CARDIOVAS CHIM DISONES 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

Director

Funerai

À

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours after death with it Department of Haalib and Mental Hygiana. Important: If item 27 is marked other than "natural", or items 23a or sany inlury or other traumatic event, the Medical Examples may be marked by the Medical Examples.

Maryland 21215-0020

Baltimore,

tha Maryland

Examiner Physician/Medical ò Completed Certification:

ig physician and es the burial-transit attending I signed by the atte should

Division of Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completaly filled in by the funaral director.

> State Registrar

edicai

KOLANDO

31. Data filed (Month, Day, Year) FEB 1 7 1999

High

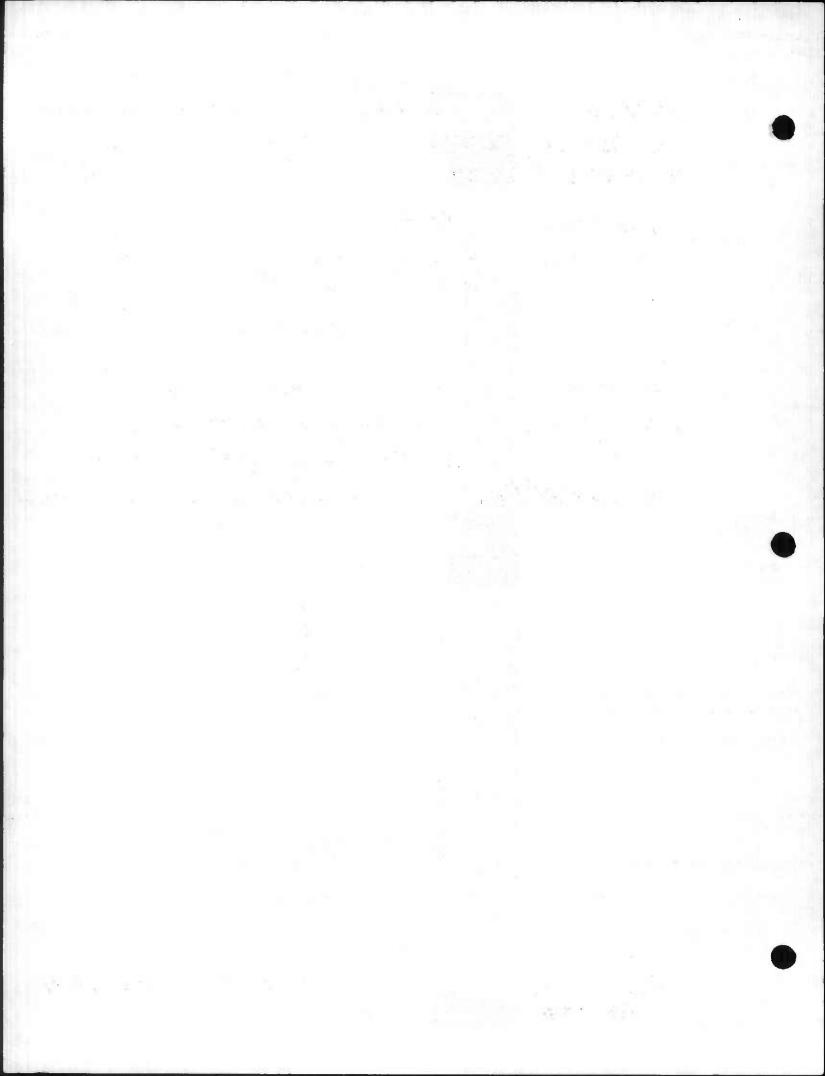
West

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

007463

Street Ection MD. 21921



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 16, 1999 **Physician** 0945 Frances Catherine Watson /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner Elkton
| If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year November 10, 595 Appleton Road
5. Social Security Number 6. Se 7. Age (In yrs. lest birthday) if Under 1 Year Birthplaca (Stete or Foreign Country) **Funeral** Year) Days 1 M 20 F Months 1916 Virginia 82 Director 223-18-9720 Usuet Residence of Deceden with the Maryland 10d. Inside City Limits Peges 1 end 2 should be filed within 72 hours efter death with the Marylan ent of Heatth and Mental Hygiene.
Int: if item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic avent, it a Monical Examiner must be notified at 10a State 10h County 10c City Town or Location 1 TYes 2 NO No Director Maryland Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21921 595 Appleton Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritai Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 White 1 ☐ Yes 2 ☐ KNo Specify: Specify py 3 Nidowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) In her own home 10 Homemaker 18. Mother's Neme (First, Middle, Maiden Sumeme) 17 Father's Name (First, Middle, Last) Etta Folsom Jenkins James Franklin Deavers 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) 595 Appleton Road, Elkton, Maryland 21921 Sharon L. Arbour/ Daughter Baltimore. 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) February 19, 20c. Location - City or Town, State 20e. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or pace. 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Fair Hill, Maryland Sharps Cemetery 21. Signeture of Funerel Servica Licensee 22. Name and Address of Fecility
Hicks Home for Funerals, P.A. West Stockton Street, Elkton, Maryland 21921 he 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final uno disto disease or condition resulting in deeth) Examiner Examiner KINJOZI physician and s the burief-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) requires that the death certificate be exec P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) use es attending ō ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2000 3 Probably 4 Unknown 1 Yes been signed t should be det Division of Vital Records. P 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy Completed page 2 hes 2 NO 1 TYes 1 □ Yes 2 □ No certificate or Attending Physician: funeral director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Deacribe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation Injury 1 Naturat 1 Yes 2 No 24 hours after death. 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) illed in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end placa, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and menner stated. edical 29a. Certifiel To the Hosp within 24 hou To the Funer completely fil (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) O'Johnell linoth

32. Registrar's Signature

State Registrar

William In Facility 1 PRESENTATION OF THE PRESENTATION OF THE PERSON OF THE PERS The Ref College Country of the Artist Co.

State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month Physician-4Pshur WAYNER Fe6 rucry 16, 1999, ocation of Death 4c. County of Death 1800 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 8. If Under 1 Year 9. Birthplece (State or Foreign Country). VIRGINIA 7. Age (In yrs. lest birthday) Date of Birth (Month, Dey, Year) **Funeral** Deys 1□M 2▼F 80 225-76-501 Usual Residence of Decedent Yrs. Director -76-5018 1 end 2 should be filed within 72 hours efter death with the Meryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ehow. 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Exposition must be notified at 1 ☐ Yes 2 No Funeral Director WORCESTER 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Rd 154/ 11. Maritel Status 2/86 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian Bleck, White, etc. ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify. py Specify: 3 Widowed 4 □ Divorced Yeer or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Hygiene. ousework Domest, nable warner 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be end Mental NKNEUN Aura 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) important: If item 27 is any injury or other Fannie E. 20b. Place of Disposition (Name of cemetery, cremetory or other place) Stockton CAHNON SNOW Hill 21864 Ma 20c. Location - City or Town, State 20a. Method of Disposition Date Buriat 2 Cremation 3 Removal from State 23/99 Yarksley Cem. Name and Address of Facility NCC-M 21. Signature of Funeral Service Licensee Acth E. Whowlon 22/71 WH MAKE Rd Act 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only one cause on each line. 23301 Approximata Intervat Between Onsat and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ettending physician end for use es the buriel-transit the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Disease or Injury that initieled events resulting In death) Lest Due to dr es e consequence of): P.O. Box 68760, Physician/Medical Dua to (or as e consequence of) ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Type 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of ceuse of daeth? 24e. Wes en eutopsy performed? Completed page 2 s hes 2X No 1 ☐ Yas 2 ☐ No certificate Hospital or Attending Physicien: director, 25. Was case raferred to medicel examiner? Be 26. Piece of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 X Inpatiant 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation s efter death. 2 No 1 TYes 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours of To the Funeral I edical 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and menner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print)

KOBINS

M.D.

32. Registrar's Signature

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HEALTHNAY

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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State Registrar William

31. Dete filed (Month, Dey, Yeer) FEB. 2 2

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wei3houst R 02 Mary 12 9:07 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MRYLAND HOSPITAL N/A 8. Date of Birth (Month, Day, Year) Tum. 17, If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplaca (Stete or Foreign Country) **Funeral** Deys Months Hours 1□ M 21 F 1920 227-14-4549 Director Virginia Usuel Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director MD Oueen Annes Centreville 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 8 109 Whitemarsh Road 21617 U.S.A. Items 23s Funeral 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Married 2 Merried "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White p 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natu any injury or other treumatic event, the limital page. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Cox Mary Woodall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 109 Whitemarsh Road Centreville, MD 21617 Carl Weishaupt, Jr. / Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 17 Feb. 1 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Glen Burnie, MD 21. Signature Funeral Service Licensee ²² Name end Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Multi-organ Examiner Examiner physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Cerebrarsen la acerdent Physician/Medical Due to (or as e consequence of) plications of Coronary artery bypass grafting USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension ð 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending investigation 1 TYes 2 □ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Division of Vitai Records, P.O. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely lilled in by the funeral director;

deeth

72 hours efter

Baitimore, Maryland 21215-0020

Box 68760,

State

(Check only one)

29b. Signature and title of certified

MD 32. Registrer's Signeture

Boulet MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

150R CUELT

S. GREENE ST 22

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

D 44498

29d. Date signed (Month, Day, Year)

BATTIMOLE MD

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental HygieneQ Q Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month BERRY 11:40A CHERYL MAR 1999 6 4e Facility Neme (II not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death of Maryland Medical Center Baltimore University 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days Hours Months 1 M 200F 49 214-56-3962 Usual Rasidenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Balto Randallstown Md 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2-1133 U.5A 12 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) College (1-4or 5+) Ba Homore City Elementery/Secondary (0-12) eacher Schoo 12th grade Public Naster 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mable G. Webb Handy O. Lee 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) dgar Randall stown, red Elwel Husbanet 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete Memorial 4 ☐ Donetion 5 ☐ Other (Specify) 12-99 Park 21. Signeture of Funeral Service Licansee e and Aldress of Facility F.H. Wgo. Mol 3 Wabash 212 0 Svenue 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heaf failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) nemmen has vania Due to (or es a consequence of) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated avants resulting in death) Lest Due to (or as e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Neturel 5 Panding Investigation 1 □ Yes 2 □ No

attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 signed by the a this funeral After ours after dean

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Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiere. Important: if feen 27 is marked other than 'n any injury or other her.

Physician

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/Medical

Director

Funeral

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Certification:

edical

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Death

2 ☐ Accident

3 ☐ Suicida

28a. Dete of Injury (Month, Day Year) 6 Could not be determined

281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one)

29b. Signeture end title of certifier x aluna

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29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21201 22 S. MD MURPHY MO Greene 31. Deta filed (Month, Day, Year)

State Registrar

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To the Hospital o within 24 hours at To the Funeral D

Katur mina Hur.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Day **Physician** February 27,1999 2:35 Am oseph /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) Examiner Baltimore Traumo N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 M 2□ F Yrs. 35 Sept.6,1963 Director 215-92-0576 Maryland Usuel Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 █No Dundalk Baltimore Maryland Direct 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21222 United States 213-A Patapsco Avenue Funeral deeth 12. Was Decedant Evar in U.S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Reca - American Indian 11. Maritel Status Bleck, White, etc. filed within 72 hours eftar Hygiena. 1XXes 2□No If Yes, Give Yaer or Detes:1987-92 1 Never Married 2 Married 10. 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White "naturel". Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Years Mold Mechanic Mechanic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe eny Injury or other traumstic avent 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James F. Baker Nancy E. Dieter 19a. Informent's Name/Reletionship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) John Baker 319 South Eastern Terrace Essex, MD 21221 20b. Place of Disposition (Nema of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1€ Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion_5 ☐ 9ther (Specify) 3/4/99 Owings Mills, MD Forest V.A. Cem. 21. Signature of Fungful Service Licetipes 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Closed Head-Injur Chrs Examiner Due to (or as e consequence of): Examiner law requires that the deeth certificate be executed attanding physician and for use es the bunal-trensi 1719 Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in deeth) Lest Due to (or es e consequença of): Physician/Medical Dua to (or as a consequence of) Did tobecco use contribute to the ceuse of death? detached f Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evalleble prior to completion of cause of death? Completed been cartificate has The 1 ☐ Yes 2 No 1□Yes 2□ No Physician: 25. Wes cese referred to medical exeminer? Be 26. Place of Death (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No this funeral 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: Affer Injury or Attending 1 Neturel 5 ☐ Pending 6:00 PM 1 Yes 2 No death. I Director: Af investigation 2-26-99 Fall 2 Accident 6 Could not be Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

Building filled in by after 4 Homicide Baltimore within 24 hours a
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completely filled 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifie

29c. Licansa number

MD

m.D. 32. Registrar's Signeture

22

person who completed cause of death (Item 23e) (Type, Print)

issey

29d. Data signad (Month, Dey, Year)

March 5, 1999

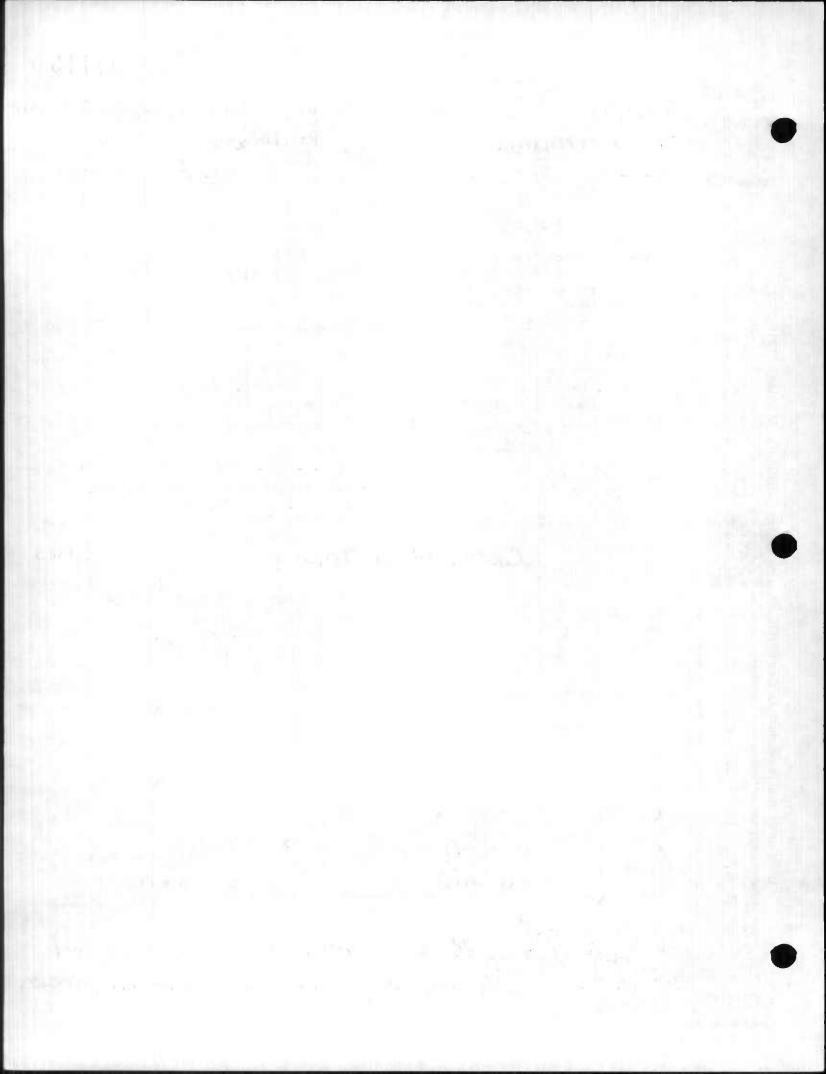
South Greene St. Baltimore m.D.21001

Division of Vital Records, P.O.

State Registrar (Check only one)

29b. Signative a

30. Name an



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Rairett Month Robert March 030 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Randa (15Town Mospitul Center 540/ Confan BAltimORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sev 8. Dete of Birth (Month, Day, Year) Paltimore, Md. Baltimore, Md. Days 1**X**0 M 2□ F 84 Months Hours 219-07-4229 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore 1□ Yes 2□ No Pikesville 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7610 Seven Mile Lane 21208 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16h, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Survey Engineer Engineering 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) William Joseph Barrett Minnie E. Aiken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Wellbrock-Niece 7610 Seven Mile Ln. Pikesville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory March 8. 1999 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel 23a. Partly Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

Approximate Interval Between Onset end Deeth Immediete Ceuse (Final 2 weeks Preumonia disease or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown remia 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier

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Baltimore, Maryland 21215-0020

Registrar

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31. Date filed (Month, Day, Year) MAR 8

29b. Signature and title of certifier

5401 old Court Road Randallstom

29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Levin Knort

Center Northwer Hospital

32. Registrar's Signeture

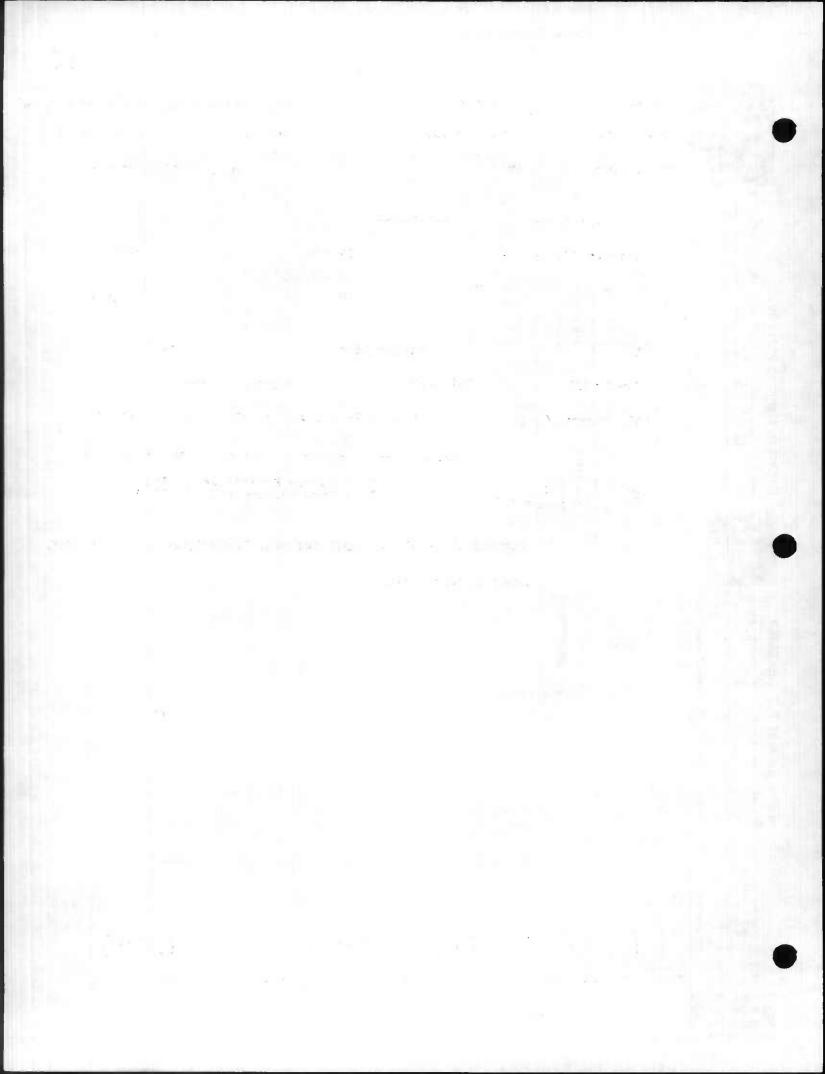
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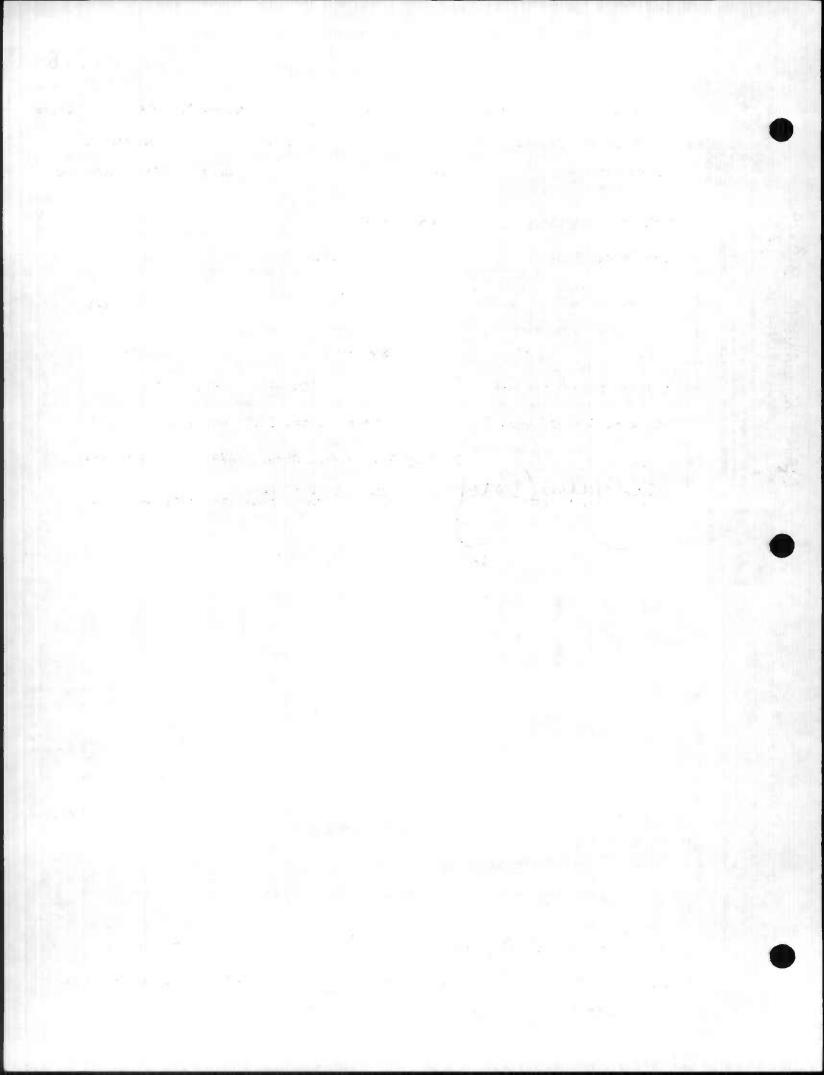
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Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth dent's Name (First, Middle, Last) 5:00 a.m. **Physician** 5, 1999 4c. County of Deeth /Medical 4b. Cify, Town, or Location of Deeth (If not institution, give street and number) **Examiner** hester Nursing BA Himo RO 6. Sex last birthday) 15 M 2 F Months Deys Hours Director Usual Residence of Decedent the Meryland State 10b. Count 10o/City, Town or Location 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours efter death with the Menylar neart of Health end Mentlar Hygiaen. Intent of Health end Mentlar Hygiaen. Int: If ferm 27 is marked other than "naturel; or items 23a or 23a-f show any or other traumatic event, the Meul rail Examines must be notified as 1 Yes 2 No Director 10g. Citizen of What Country? Funeral 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 M Never Merried 2 ☐ Merried 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondery (0-12) 18. Mother's Name (First, Middle, Maiden Sumeme) 17 Father's Neme (First, Middle, Last) Be 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 Creplation 3 Removal from State Dependent Important: If any injury or 8 Other (Specify) 4 Donation le disease, of complications that ceused tha death. Do not enter Approximete Interval Between Onset and Death **Physician** /Medical Immediale Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician end the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury Ithal initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequenca of): 80 for use signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? Candida of aral Counte Completed 24a. Wes an autopsy performed? hes page 2 2 14 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate or Attending Physician: funeral director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Realdence 8 Other (Specify) 20 No 1 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1/QNatural 5 Pending 1 Yes 2 No 24 hours efter deeth.

Funeral Director: A Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Nertifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the F 29c. License number 29d. Dete signed (Month, Day, Year) Challou MD D26748

State Registrar

31. Dele filed (Month, Dey, Year)

32. Registrar's Signature

30, Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

1999

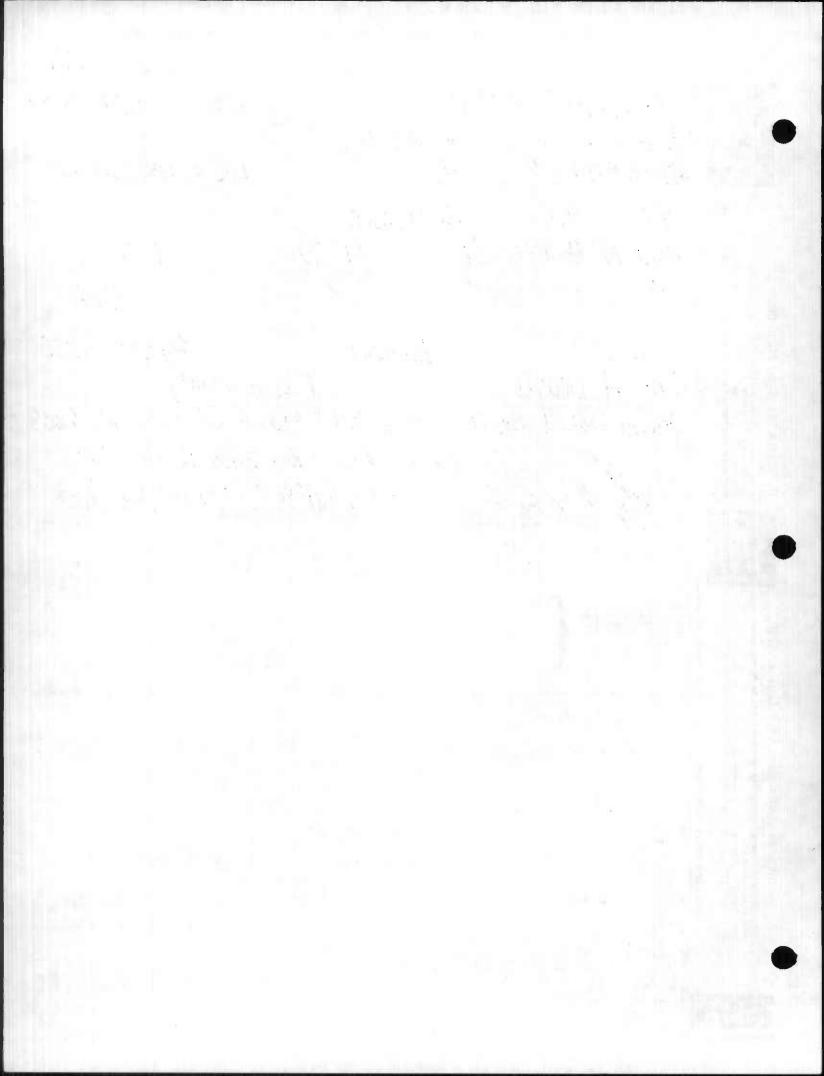
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 815 AM MADELINE DAVIS 1999 MARCH 06 4b. City, Town, or Location of Death 4e Facility Name (If not institution, giva street end number) 4c. County of Deeth BALTIMORE HOSPITAL SAMARITAN N/A If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) If Undar 1 Yaar 5. Sociel Security Number Birthpleca (State or Foraign Country) 6. Sex 1□M 2X)F Months | Deys Yrs. 05-07-1926 West Virginia 217-26-5119 Usuel Residence of Decedent 10d. Insida City Limits 10e. Stela 10b. County 10c. City, Town or Location 1 Yas 2 No Parkville Baltimore Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? United States 21234 2601 Taylor Avenue 12. Was Decedan! Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; 13. Wes Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Nevar Married 2 Married White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18 Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Alice Foy Cave Lee 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. fnforment's Name/Reletionship (Type, Print) Baltimore, Maryland 2601 Taylor Avenue Ronald E. Davis / Husband 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 □ Cramation 3 □ Ramovel from State 4 □ Donetion 5 □ Other (Specify) 3/9/99 Baltimore, Maryland Moreland Mem. Park 21. Signeture of Funeral Service Licansee Michael E. Canapp 22. Name end Address of Fecility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiec or respiretory arrest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsat end Deeth fmmediate Cause (Final disease or condition resulting in death) ONE DAY Due to (or es e consequence of) Due to (or es a consequence of): Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

The law requires that the death certificete be axecuted

certificate has

of or Attendath.

rai after death.

rai Director: After this certificate.

--- the funeral director, pr or Attanding Physician:

To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th

o

Division of Vital Records,

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified as

2 should be filed within 72 hours after death on and Mental Hygiene.
Is marked other than "natural", or items 23.

Maryland

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Examiner attending physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury Ihel initiated events resulting in death) Last Physician/Medicai signed by the a

by

Completed

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2

Certification:

edicai

DIABETES

24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

25. Wes case referred to medical exeminer?
1 ☐ Yes 2 ☒ No

Hospital: Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Pleca of Injury - Al home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

MD

1 Yas 2 No

29a. Certifier (Check only one) TX Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred el the time, date end placa, and due to the cause(s) end manner stetad.

29b. Sigrature and title of certifier

29c. Licanse number

29d. Data signed (Month, Dey, Year)

Kotelsh, MD

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BALTIMORE

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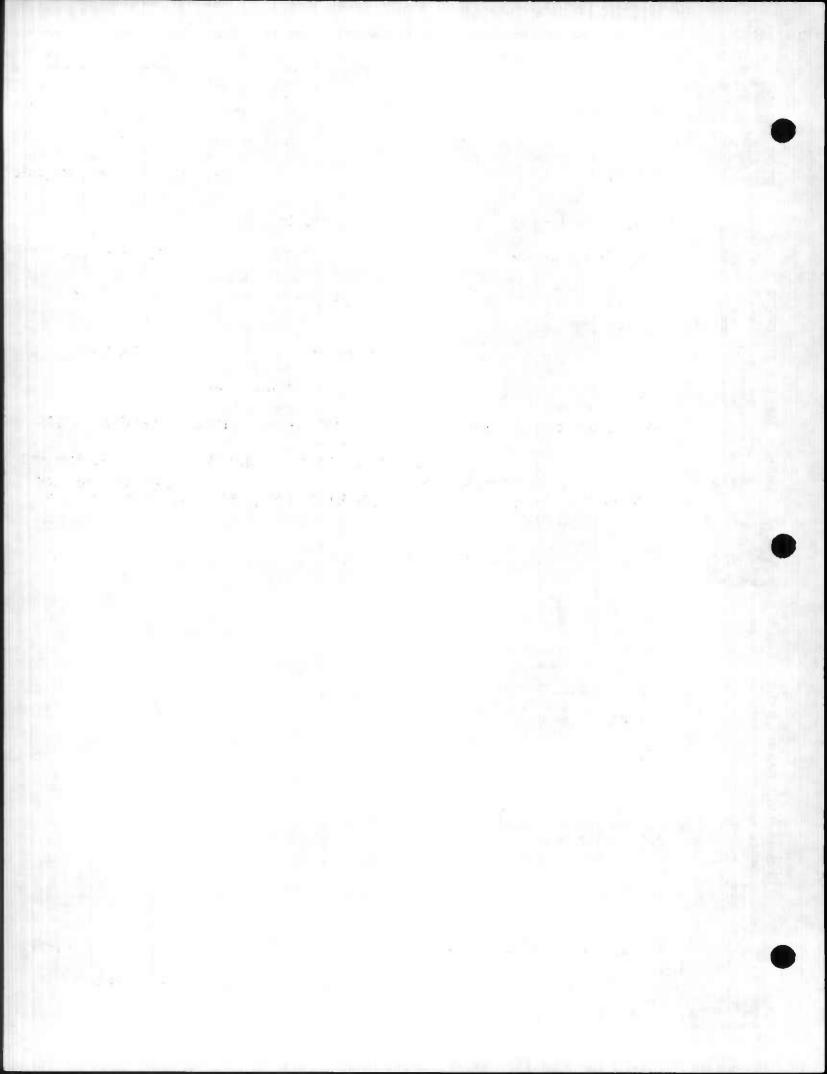
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

LOCH RAVEN BLVD 5601 KOTEISH MD

31. Dete filed (Month, Day, Year) MAR 8 1999 2. Registrer's Signeture

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Name (First, Middle, Last) March 5, 1999 8:20 AM **FOERSTER** KATHE **GERTRUD** 4b. City, Town, or Location of Daeth 4e Facility Neme (If not Institution, give street end number) 4c. County of Deeth Baltimore Towson Gilchrist Hospice Center If Undar 1 Year If Under 24 Hrs. 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1□M 2ØF Months Deys Hours Min. 79 Yrs. 218-36-2214 October 8,1919 Germany Usuel Residence of Decedent 10e. Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 TYNo Westminster Carroll Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21158 Germany 4187 Wine Road 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - Amarican Indian 11 Marttel Status Bleck, White, etc. 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Marriad 2 Married 1 Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mothar's Nema (First, Middle, Meiden Sumame) Scholz Gertrud Fabian Gustav 19e. Informent's Neme/Reletionship (Type, Print) Mrs. Margit Sharff - Daughter 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Same as # 10 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/8/99 Baltimore, MD Parkwood 22. Neme end Address of Fecility 21. Signature of Funeral Service Licensee Baltimore, Maryland 5305 Harford Rd. Leonard J. Ruck, Inc. 23e. Pert1. Enter the diseasa, or complications may ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failura. List only one cause on each line. Approximete Intervel Between Onsat and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) tral Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disaasa or injury that initieled events resulting in death) Lest Due to (or es a consequence of) Dua fo (or as a consequance of): Pert II. Other elanificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings aveilable prior to 24e. Wes an eutopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese raferrad to medical axaminar? 26. Place of Daeth (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 40 \$ 101 Ce 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Deeth 28d. Dascribe how injury occurred 28e. Data of Injury (Month, Day Yaer) 28h Time of 28c. Injury at Work? 1 Naturel 2 Accidant 5 Panding Investigation 1 TYes 2 TNo 6 Could not be datarmined 3 ☐ Suicida Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida

law requires that the death certificate be executed or Attending Physician:

physician end the buriel-transit ed by the deteched Division of Vital Records, P.O. signed by t director, page 2 s this

Physician

/Medical

Examiner

Directo

Funeral

by

Funeral

Director

r is marked other than "naturel", or items 23a or 28a-f ahow traumatic event, the Medical Examinar mast be notified at

should be filed within 7: nd Mental Hygiene. merked other than "n.

and Mental

permit. Peges 1 and 2 sh Department of Health and Important: If Item 27 1s m any Injury or other traum pnce.

Physician

/Medical **Examiner**

Physician/Medical Examine

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Certification:

Medical

with the Merylend

Baltimore, Maryland 21215-0020

20 Am

To the Hospital or Attendir within 24 hours efter death.
To the Funeral Director: Al completely filled in by the fu

15 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daeth occurred at tha tima, data and place, and dua to the causa(s) end menner stated. 29e. Cartifiar (Check only one)

29b. Signature and title of certifian

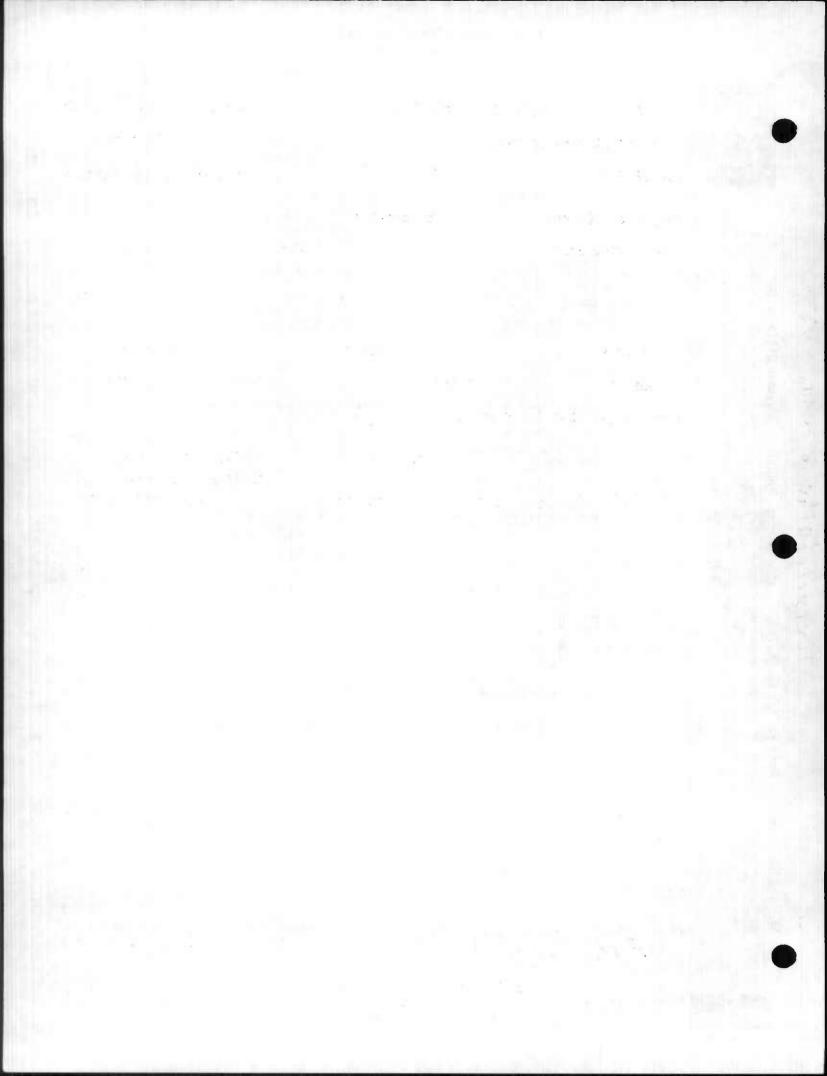
29c. License number mo

29d. Dete signed (Month, Day, Year) March 5, 1999

30. Nama end eddress of person who completed cause of death atem 23e) (Type, Print)

Charles St. Balto, Ma 2/20x 6701 32. Megisfrar's Signature

State Registrar

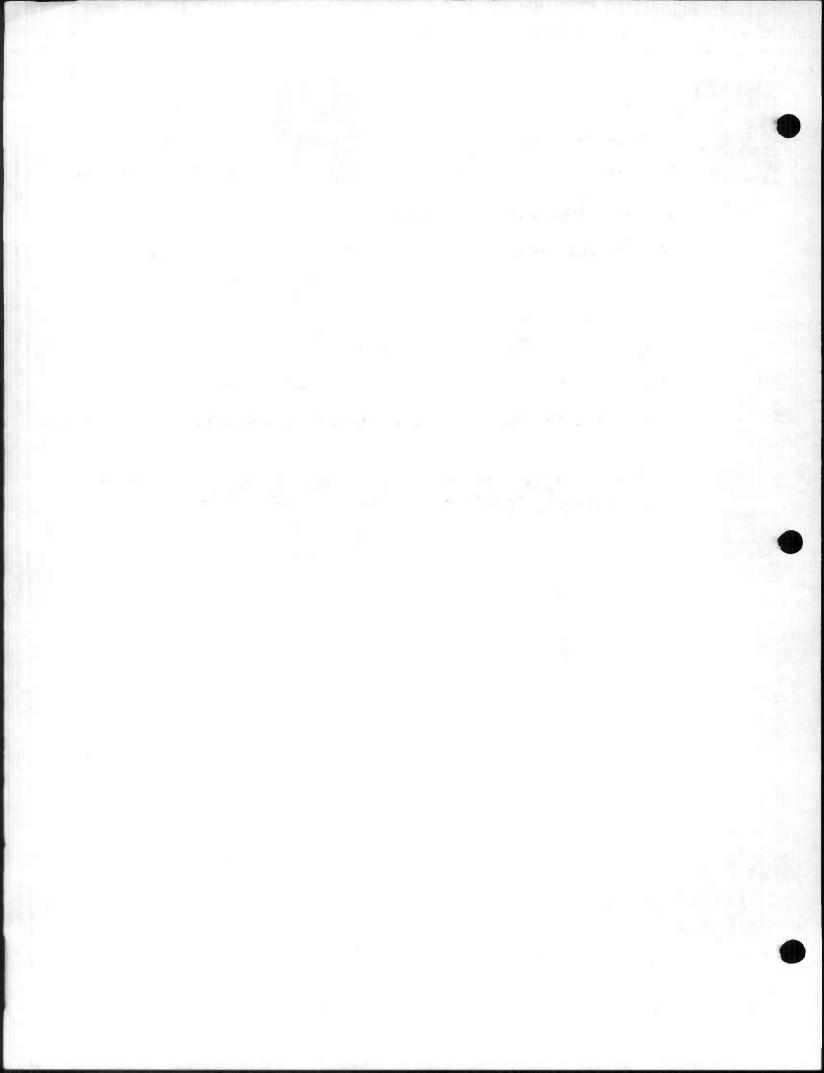


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State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, Las	1)	(Certific	ate of	Death		Reg. No. 99	U/	120	
Physicia /Medic		Mary 1	Tord					2. Date of Dea	Day 28	Year 99	Tima of Death 4:45F	
Examir		4a. Facility Name of not institution, give					4b. City, Town, or Baltimo	Location of Death	100	4c. County of Death Baltimore City		
Funerai Director		217 07-0321	1x 7. Ag ☐ M 2∱2 F	79 Y	rs. If Un Monti	der 1 Yaar hs Days			h /, Year)		(State or Foral	
show		Usuel Residence of Decedent 10a. State 10b. County	011	10c. City, Town							inside City Limit	
or 28a-f	Director	10e. Street and Number	re City	Baltim		Zip Code			10g. Citizan of V		1 ☐ Yes 2 ☐ N	
72 hours efter deeth with the Maryland natural; or frema 23e or 28e-f show pical Enamos must be notified at	Funeral	4701 Hamilton Av 11. Marital Status 1 Never Marriad 2 Married	enue 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		13. Was De If Yes, s	2120 cedant of specify Cul	6 Hispanic Origin? (S ban, Mexican, Puer	Specify Yas or No- to Ricen, etc.)	U.S.A.	e - American i ck, White, etc.	ndian,	
n 72 hours of "natural", or exical Exam	by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed	If Yes, Give Yaer or Dales:			2 No			Specify 16b. Kind of Bi			
iene. than	Completed	(Specify only highast grad		(16a. Decedent's Usual Occupation (Give kind of work done during most of wo. life. DO NOT use retirad) COOK			orking	Churc		ry	
E the	Be	17. Father's Name (First, Middle, Last) Joseph John Ford					ame (First, Middle, Maiden Surname)					
2 should be and Mental Is marked o	Lo	19a. Informant's Name/Relationship (7	uno Print)	10h	Moiling Adde	nee /Strac	Mary O'	Donnell	or City or Tour	State 7in Co.	do.)	
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permit. Pages 1 en Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burlal 2 Cremation 3 4 Donation 5 Other (Specify		20b. Place of I		Name of		Date	20c. Location -			
Departr Imports any inju		21. Signature of Funeral Service Licens Ronald S.	Wade Di	rector			ess of Facility atomy Boa e, Maryla			imore	Street	
hysician		23a. Part I Enter the diseasa, or comp shock or heert feilure. List only of	lications that causac ne cause on eech li	the death. Do no						Inte	proximate erval Between set and Death	
/Medical Examiner	er	Immediate Cause (Finel disease or condition resulting in death)	a d	Due to (or as a co	onsequence	of):				4	years	
ng physician and es the buriel-fransit	Examiner	Sequentially list conditions, if any, laeding to immediate cause. Enter Undarlying	b									
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has been signed I	Completed t								an autopsy med?	availab	autopsy finding ble prior to etion of ceuse th?	
page	Сош								1 ☐ Yes 2 ☐ No		s 200No	
this certificate	o Be	25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	26. Place of Deeth (Checospital: 1 Inpution 27 FBI/Outpution 27								
£ 10	-	27. Manner of Death 1 Natural 5 Panding 2 Accident Investigation	1 ☐ Inpatie 28e. Date of Inju (Month, Da		ne of	28c. Inju	4 Li Nursing I	Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred				
불통도	Certification:	3 Suicide 6 Could not be determined	28e. Place of injuding, at	28f. Location (Street and Number or Rural Route Number, City or Town, Stata)								
within 24 hours	edical	29a. Certifier (Check only one) Certifying Phy	alcian: To the best oner: On the basis of and manner sta	examinetion end/	deeth occurr or investigat	ed at the t	ime, date and place opinion, death occ	e, and due to the durred at the time, d	cause(s) and ma date and place,	anner es steted and due to the	d. ceuse(s)	
within 2 To the comple	Me	29b. Signature and title of cartifiar	0			29c. Licen	se number		29d. Date signe		Year)	
		I sus to	fued-	im			\$679		3/2/	99		
		30. Neme and address of person who of Susan M. Friedu		eath (Item 23e) (T	ype, Print)	Fact	ern Aue	Balk	noru k	LD 21	224	
Sta	ite	31. Date filed (Month, Day, Year)		er's Signature	110	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· · · jve	00018	-5000		-04	

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Item#8 cerFHG769 3/8/99 EW 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month (DARRETT 1.30 hm BERTHA 24 02 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Ma Good Samaritan Hospital 8. Data of Birth 1910 (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Number Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) 1□ M 2🗗 F Months Days 88 Yrs. 219-18-2730 Usual Rasidence of Decedant June 28, 1920 Virginia 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Tas 2 No Marykan 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4700 Hartora 21219 USA Noad 11. Marital Status Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No Specify Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) HouseKeeper Domestic unknown nknown 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Unknown Un Bnown 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19b. Mailing Addrass (Straet and Name RD. Ballimore, MD. 212 15 3523 Denison RD. Ballimore, MD. 212 15 Data, 20c. Location - City or Town, Stata Neu Didney 20a. Mathod of Disposition Danie 5 20b. Place of Disposition (Nama of cematary, cramatory or other place march 1 ■ Burial 2 □ Cramation 3 □ Ramoval from State 5,1999 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore 21. Signature of Funaral Sarvica Licensaa 22. Nama and Addrass of Facility Douglass Funeral Service 1701 Mc Culloh Street, Baltimore, MD, 21217 plications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, one cause on each line. Immediate Causa (Final disaasa or condition resulting in daath) Accident Cerebrovascular Dua to (or as a consequence of) nertensiun Saquantially list conditions, if any, leading to immadiata ceuse. Enter Undarlying Cause (Diseasa or Injury that initiated avents rasulting in death) Last Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of deeth? Memia 1 | Yes 2 | No 3 | Probably 4 Detriknown 24a. Was an autopsy parformed? 24b. Wara autopsy findings available prior to completion of cause of death? Osteo arthribi Domentia 1 Yas 2 TNo 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medical axaminer? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Daath 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accident

Examiner physician and s the buriel-transit Records, P.O. Box 68760, signed by the attending to be deteched for use es

Division of Vital

Physician /Medical

> Examiner Physician/Medical by Completed Certification:

Physician

/Medical

Examiner

10a Stata

Director

Funeral

by

Completed

Director

the Marylend

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryle Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumetic event, the Medical Examinat must be notited at

Baltimore, Maryland 21215-0020

6 Could not be determined

28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)

821

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

🗠 Certifying Physician: To tha best of my knowledga, daath occurred at tha time, date and place, and dua to the causa(s) and mannar as stated.

Bulhimore

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

Smit 306

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State Registrar

Medical

31. Data filad (Month, Day, Year) --

29b. Signature and ulla of cartifiar

3 ☐ Suicide

29a. Certifian

4 Homleide

32. Registrar's Signatura

30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

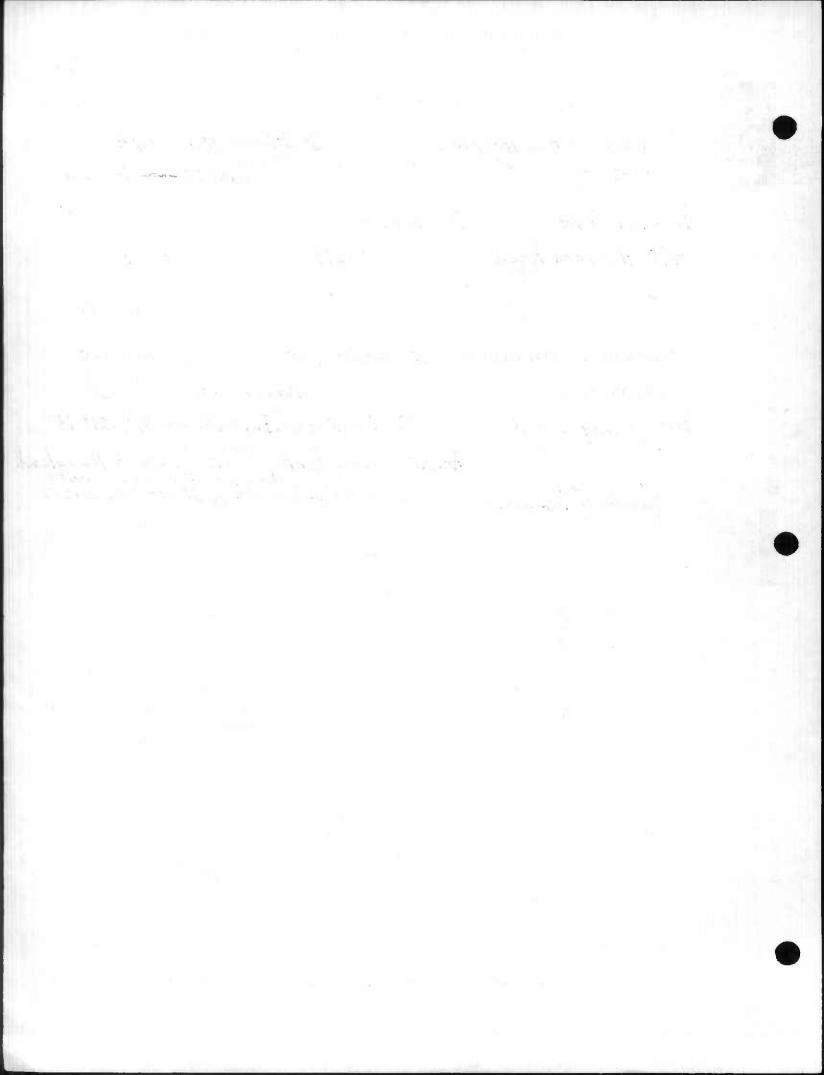
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DHMH 16 Rav 6/95

To the Hospital or Attending Physician: within 24 hours effect death.

To the Funeral Director: After this certifica completely filled in by the funeral director,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Q Amended#26 perPhyG769 3/8/99 EW Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** FEBRUARY 27, 1999 5:15 PM BESSTE **GORDON** /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** CARROLL COUNTRY CARE ASSISTED LIVING FINKSBURG If Under 1 Year | If Under 24 Hrs. | Months | Devs | Hours | Min. 5 Social Security Number 6 Sax 7 Age (In vrs. lest hirthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 216-30-9030 1 □ M 2 💢 F Yrs. 93 Director FEB. 26,1906 Usual Residence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits FINKSBURG CARROLL 1 Yas 2000 MD Director 28a-f 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 'natural', or flams 23s or must be 2455 BALTIMORE BOULEVARD 21048 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yaar or Detas: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Be 2 should be fin and Mental Financial of permit. Pages 1 and 2 should by Department of Health and Meria Important: if Itam 27 is marked any injury or other traumatic es GOLDSTEIN To REUBEN **JENNA** (UNKNOWN) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Coda) 1706 BOLLINGER ROAD - WESTMINSTER, MD LEONARD GORDON / SON 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stele 20a Mathod of Disposition Data 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 3/2/99 MIKRO KODESH BETH ISRAEL BALTIMORE, MD 4 ☐ Donetion J ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Pervice Lie 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Inter the disease, or complications that causad the death. Do not entar tha mode of dying, such as cerdiac or respiratory arrest, shock or haart failura. List only one cause on each line. Approximeta Intervel Batween Onset and Deeth Physician Cardiac arrhythmia Immediata Cause (Final diseese or condition resulting in deeth) /Medical Examiner requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiata ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events rasulting in deeth) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown enster Records. by 8 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Wes en autopsy Completed Deen performed' 1 Tyes 1 ☐ Yes 2 ☐ No certificate Attending Physicien: 25. Was case referred to medice! Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) iving Facilit 1 Yas 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 ☐ Accidant Invastigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28a. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fune

Cortifying Phyelcian: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es steled.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) end menner steled. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. Licensa number Vojvala

30. Name end eddrass of person who completed ceuse of daath (ftem 23a) (Type, Print)

1130 Baltimore Blvd Westminster MD 21157 NAYAN VAYWAZA

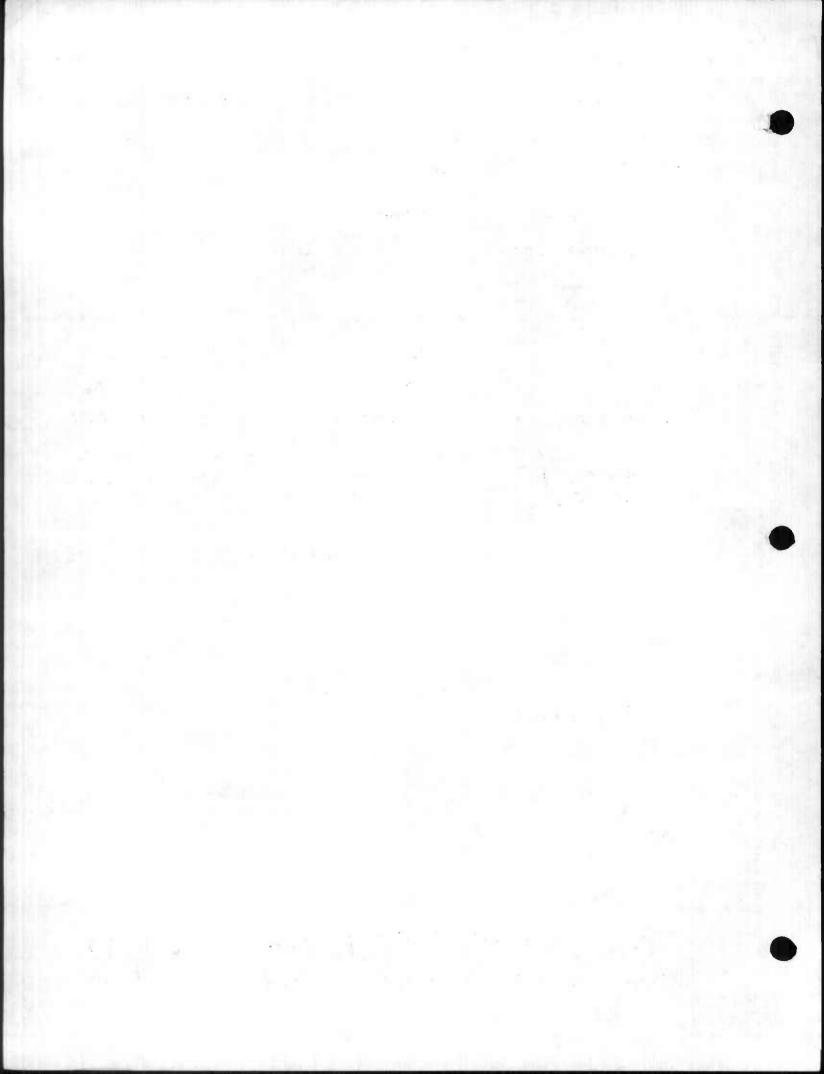
State Registrar

Medical

29a. Certifia:

31. Date filed (Month, Dey, Year)

MAR 8 1999 32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Death Vonth George Lee Harris 16 ly (If not igstitution, give street and number Location of Deeth 4c. County of Deeth Social Security Number Under 24 Hrs. 6. Sex Age (in yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days Hours 11XM 20 F Min 220-09-4597 03 16 P.A Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Md Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3251 Westmount Ave 21216 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify Black 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Unk College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed 6th grade 6th grace 17. Fether's Name (First, Middle, Last) Unknown 18. Mother's Neme (First, Middle, Meiden Sumame) UNK Annie 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3251 Westmount Ave, Baltimore Md 21215 Vivion Stepney-Daughter 20b. Piece of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 【Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory Inc 3/8/99 Baltimore, Md 21. Signature of Fuperal Service License 22. Name end Address of Fecility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease, or complications that eached the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of hear feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Ceuse (Fine) disease or condition resulting in deeth) Anaemia Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest allura Due to (or as a consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 D Onknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 🗆 Yes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of

Examiner The law requires that the death certificate be executed pue Box 68760. ettending physician for use es the burie hed for P.O. s been signed by the should be deteched Division of Vital Records, After this certificate has f or Attending Physician: efter deeth. Director: After this certifica in by the To the Hospital of within 24 hours of To the Funeral D completely filled

Physician/Medical

Physician

/Medicai

Examiner

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must be notified at

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Pages 1 and 2 Department of Health reportant: If Nem 27

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Physician /Medicai

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21215-0020

Maryland

Director

Funeral

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λq Completed Be 25. Wes case referred to medical 2 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homlcide Medicai

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(e) end menner stated.

29b. Signeture end title of certifier Swammether

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

7n.D. Go Maryland General Hospital Jawahar Swammathan

31. Dete filed (Month, Dey, Yeer)

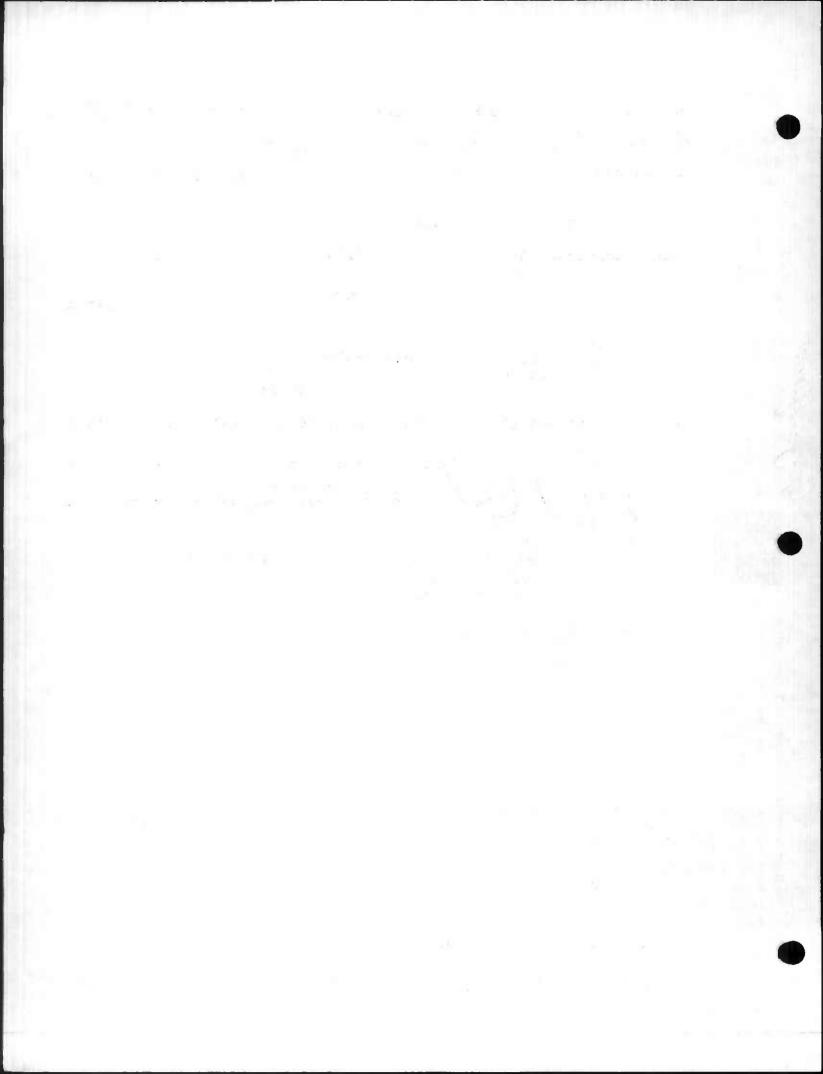
32. Registrer's Signeture

Registrar 1999



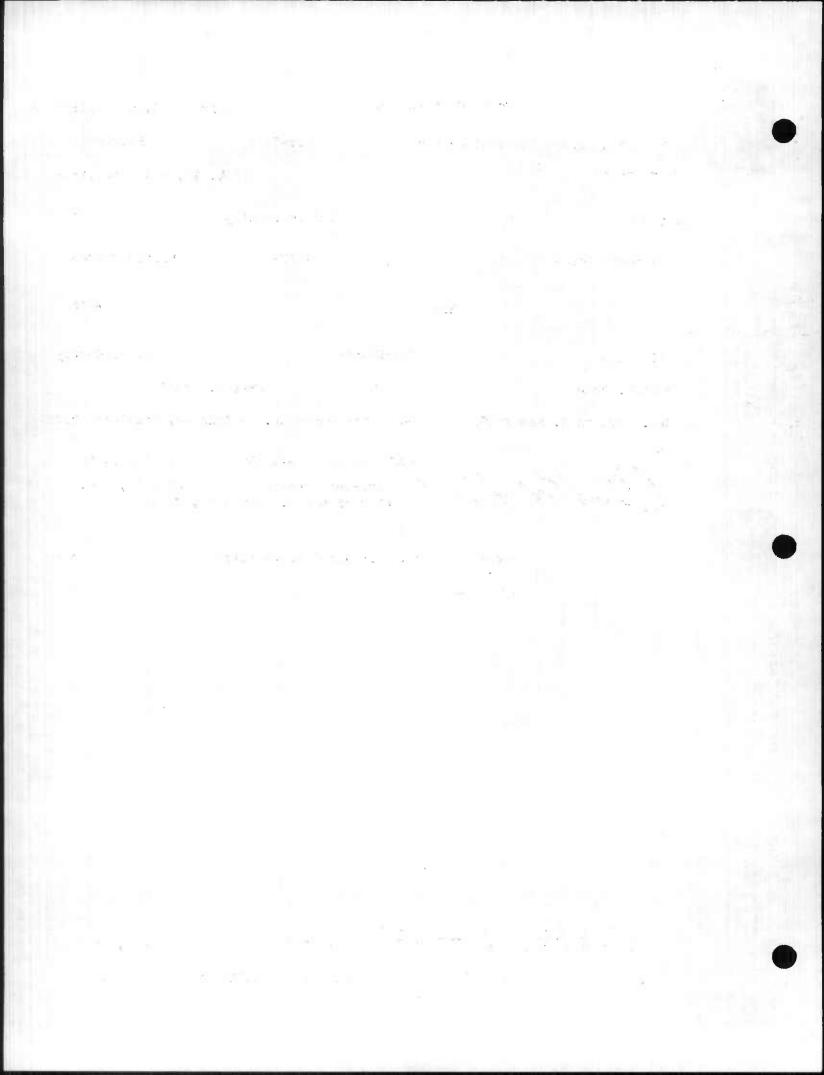
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State



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1. Decedent's Nama (First, M 4a Facility Name (if not institute franklin Sq 5. Social Sacurity Number 215-14-0539 Usual Residence of Decedent 10a. State 10b. County 1and 10e. Street and Number 804 South Po 11. Marital Status 1 Never Married 28 M 3 Widowed 4 Diopectify only high Elementery/Secondary (0-1	ution, give s [uare 6. Sax 1123]	treet and number	1 Cent Age (In yrs. 77	ter lest birthday) Yrs.		ar 1 Vae	4b. City, Town, or Rosedal		Day ary 25,1	y of Death	3. Tima of Deeth	
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	nding	28a. Date of Ir (Month, I	njury De <i>y Year)</i>	28b. Time o Injury				28d. Describe how Injury occurred				
2 Accident inv	estigation				M	1[☐ Yes 2 ☐ No	No				
		28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
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Donel	()US	Mand		MD		F	D 187286		March	8, 19	999	
30. Name and address of per	son who cor	npieted cause of	f deeth (Iter	n 23e) (Type.	Print)							
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200	John F. Hahr 19a. Informant's Name/Raiat Mrs. Jaunita 20a. Method of Disposition 1 Burial 2 Cremat 4 Donation 5 Othe 21. Signatere of Finest Sent 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Last Part II. Other significant conditions. 25. Was case referred to mere examiner? 1 Yes 2 No 27. Manner of Deeth 1 Naturel 29a. Certifier inv 3 Suicide 6 Code Homicide 29a. Certifier 1 Certificate one) 29b. Signature and titla of cause in the cause of personer in the cause in the ca	17. Father's Name (First, Middle, Last) John F. Hahn 19a. Informant's Name/Raiationship (Typ. Mrs. Jaunita J. H. 20a. Method of Disposition Burial 2 Cramation 3 Revice (Specify) 21. Signature of First Service (Specify) 21. Signature of First Service (Specify) 22. 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Famer's Name (First, Middle, Maiden Sureme) 18. Mother's Neme (First, Middle, Maiden Sureme) 19. Marry E. P Faef 19. Mar	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Carley Louise Hefty MARCH 1999 2209 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months 1 M 2 XF 0 N/A 06 March 03, 1999 Baltimore, Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Maryland Baltimore Co. Baltimore Directo 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 6617 English Oak Road Apt. L 21234-6775 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Biracial À 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A Infant N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown Unknown 10 Melissa Louise Hefty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miss Melissa Louise Hefty (Mother) 6617 English Oak Road Apt.L Baltimore, Maryland 21234-6775 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corporation 3/06/1999 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensea Laffixey L. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515 air 23a. Parl. Enter the discuss shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PREMATURITY ExTRAME Due to (or as a consequence of): Examiner REMATURE RUSTURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 6 HOURS CHIKI AMMINITIS Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1□ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

physician and the burial-trans 980 signed by the a this funeral after death. To the Hospital of within 24 hours at To the Funeral D completally filled i

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Director

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altimore, Maryland

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Pages 1

Physician /Medical

Examiner

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

MAR 8

5 Pending investigation

6 ☐ Could not be

27. Manner of Death

132 Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Hornicide

(Check only one)

29b. Signature and title of certifier

M. Ma

Certification:

edical

State

3333 ma 32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

100

CALVERT ST. Sum 600

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

051540

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

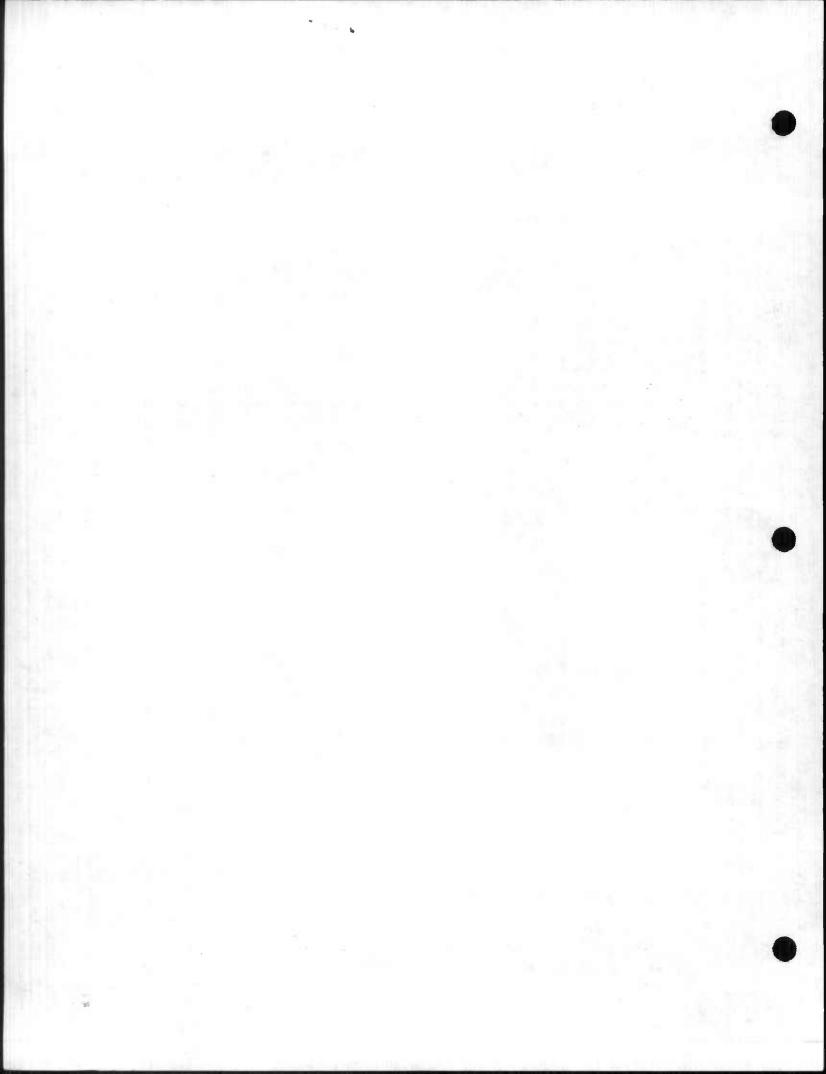
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28b. Time of

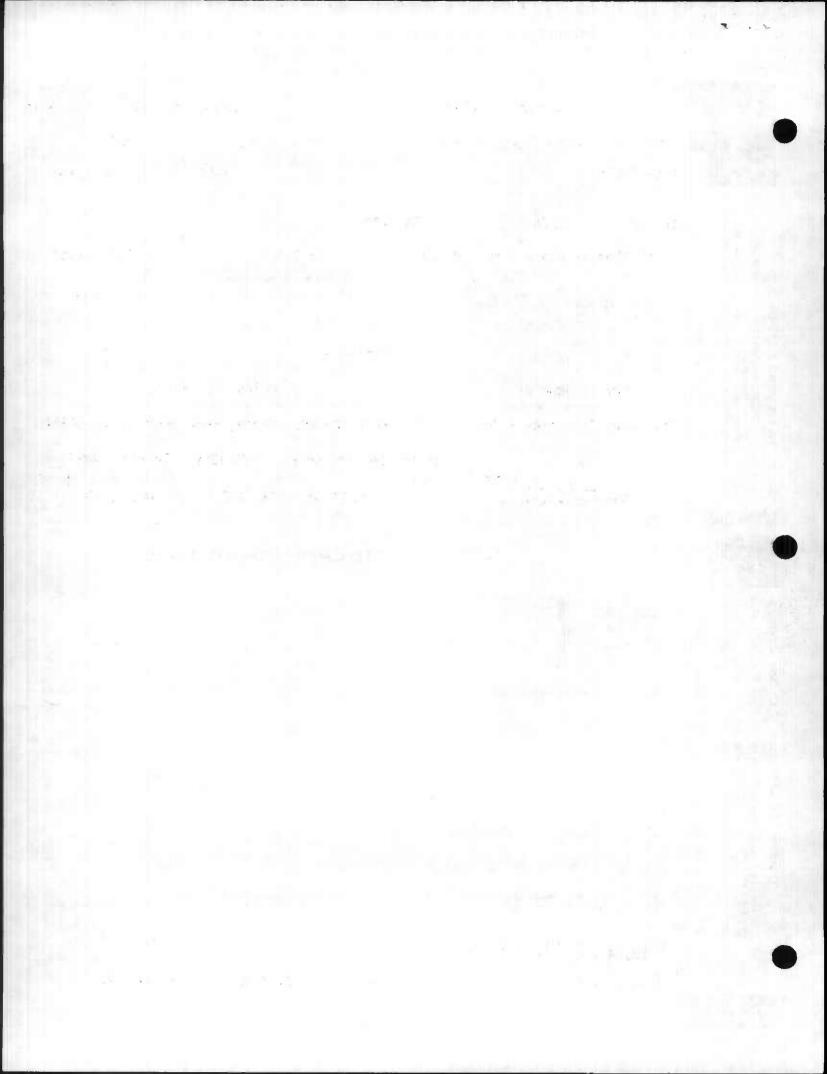
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



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	Physician /Medical		rothy Hurley		Month MARCH	MARCH 03, 1999		Time of Death 14:55 PM			
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		30, Name and eddress of person who	J- Koron	111 P		et, Balt:	imore, Ma	ryland	21201		
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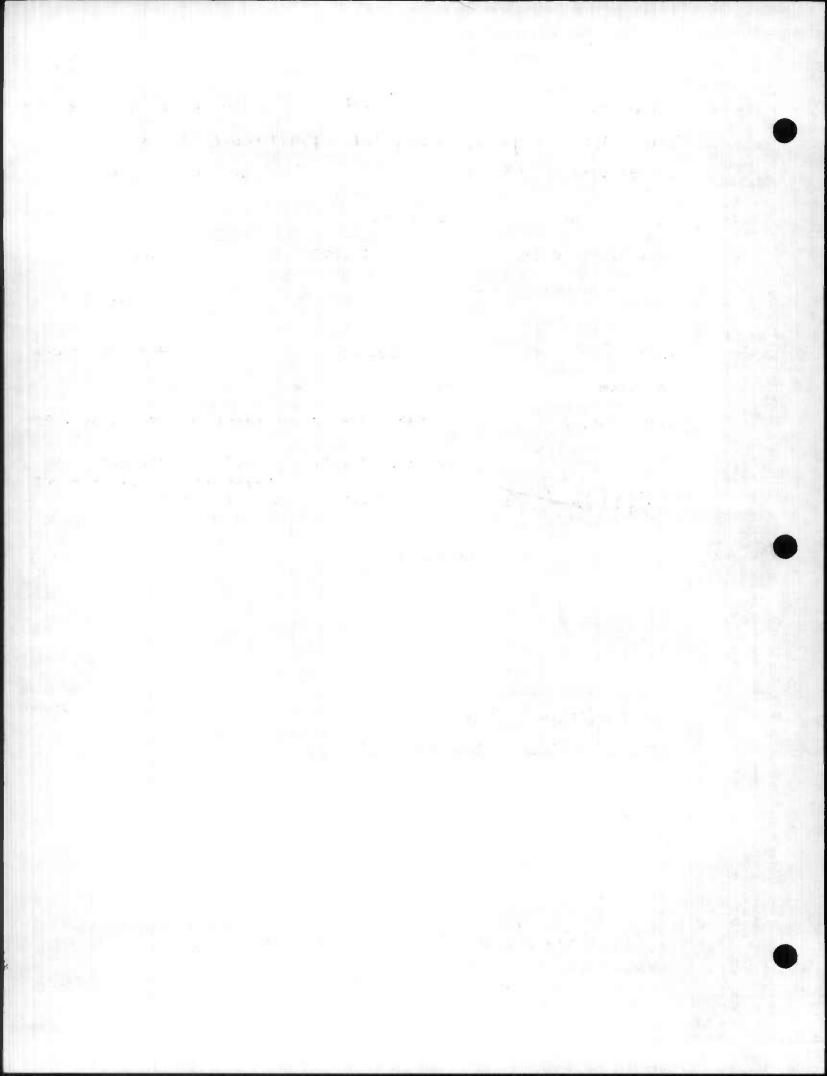


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State of Maryland / Department of Health and Mental Hygiene 9 07 127

Certificate of Death Reg. No. 07 127

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death Month Yaar **Physician** 0600 JONES 1999 IVIA Z MARCH /Medical 4a Facility Nama (If not institution, giva stree and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTI MORE
If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) NIA DEATON OPECIALTY HOSPITAL AND HOME 7. Aga (In yrs. last birthday) If Undar 1 Year Months Days 5. Social Sacurity Number 6. Sax Birthplaca (State or Foraign Country) **Funeral** Days 1 M 2 F 96 215-32-1857 Director 7-01-02 Usual Rasidanca of Dacadant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23e or 28e-f show edical Examiner must be notified at 1 Yas 2 No NIA BALTIMORE Funeral Director MD 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? death with 21230 611 HARES 12. Was Decadant Evar in U.S. Armad Forcas? 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status Black, White, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Spacify. by BLACK 3 Widowed 4 Divorced livia Jones Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 7 is marked other than "natur traumatic event, the Medical 16b. Kind of Businass/Industry 15. Decadant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) DOMESTIC NIA MUKNOWN HOME 18. Mothar's Nama (First, Middla, Maiden Sumema) 17. Fathar's Name (First, Middla, Last) Be Pages 1 and 2 should be Innent of Health and Mental KOBERT JONES JANE UNKNOWN 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Straet and Number or Rural Route Numbar, City or Town, Stata, Zip Coda) of Health a Itam 27 is r other tra 1214 NOTTINGHAM KO., MD. 21157 ENORA CAMPBELL WESTMINSTER 2.0b. Placa of Disposition (Nama of camatary, crematory or other placa) 20a. Mathed of Disposition Data 20c. Location - City or Town, Stata permit. Pages Department of Important: If it any Injury or o 1 ☑ Buriel 2 ☐ Crametion 3 ☐ Ramoval from Steta MOUNT ZION CEMETERY 3-9-99 BALTO. MD 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signatura of Funara Sanyica Licansaa VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIRE, BALTO. MD. 2/22

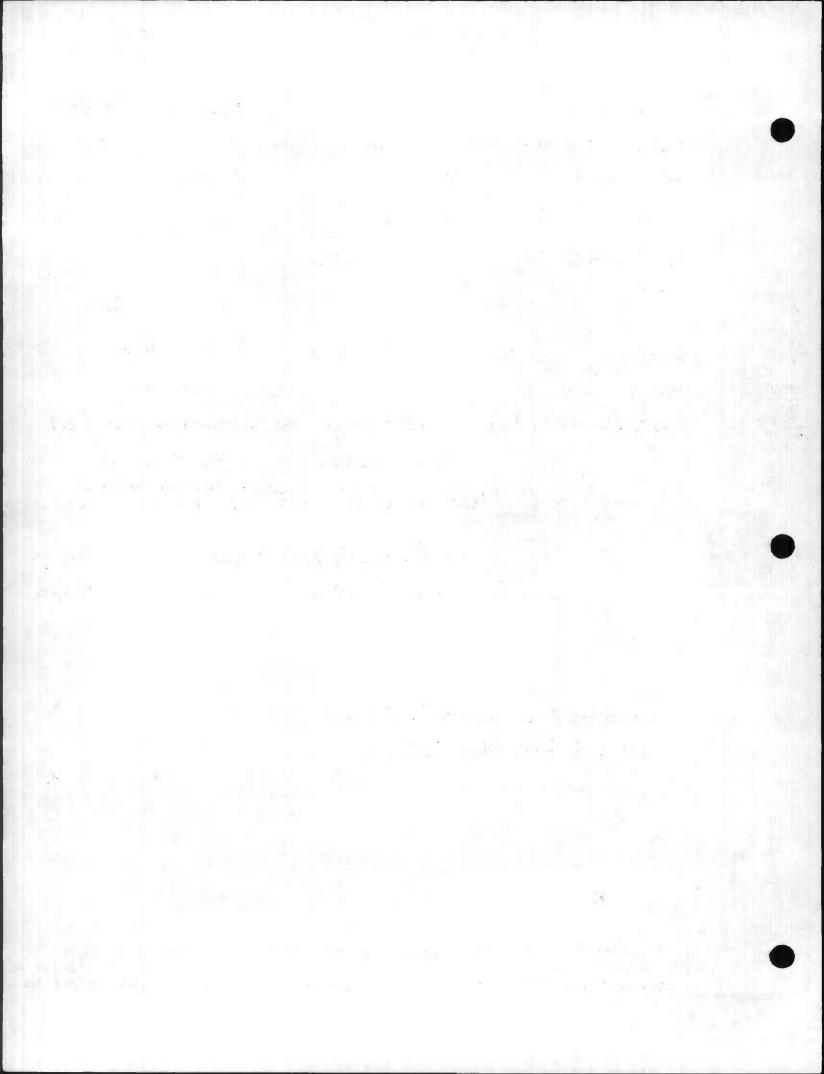
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the causa(s) and manner stated. 29a. Cartifiar edical (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa numbar 29d. Date signed (Month, Day, Year) DO 1344 30. Neme and address of person who complated cause of death (Item 23e) (Type, Print BAHLmore Hospital & Home 611 S. Charles St. Deaton S Flynn pecialty Md. 21230 Ames 32. Registrar's Signature 31. Data filed (Month, Day, Year) State

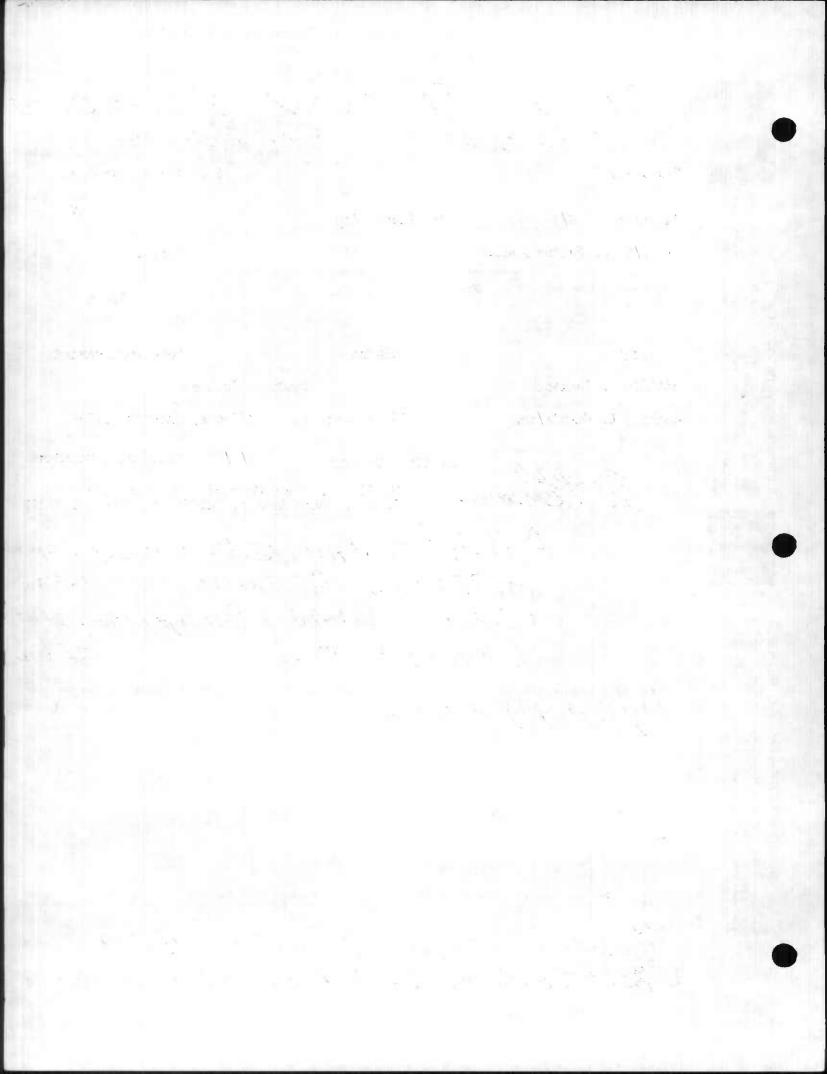
Registrar

MAR 8



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death Maple **Physician** /Medical of Death 4c. County of Death 4a Facily Name (If not institution, give street and number) **Examiner** 5. Social Security Number 7. Aga (In yrs. last birthday) # Under 1 Months | E Birthpieca (State or Foreign Country) 6 Sax Date of Birth (Month, Day, Year) **Funeral** Hours 10 M 2□ F Days 50 215-52-2783 Yes. Director 06 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Insida City Limits ral', or items 23a or 28a-f show Examiner must be notified at XX Yes 2 No Director Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 1/2 N. Fulton Avenue 21223 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, etc. 72 hours after 1 Never Married 2 Married 1□ Yes 2 No Maryland 21215-0020 "natural", or Specify Specify: Black þ 3 □ Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry filed within and Mental Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) 12th Painter Home Improvement 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be important of Health and Mental moortant. If item 27 is marked or William W. Iverson Gertrude Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony L. McNuttison 8713 Fontana Lane, Baltimore, Maryland 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/5/99 Baltimore. Maryland 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 21. Signature of Funer 22. Nama and Addrass of Facility William C. Brown Community Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Approximate Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Examiner attending physician and for use as the bunal-transit The law requires that the death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the at d be detached for significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? has certificata 210 No After this certifical funeral director, p or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 2 27. Manger of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Neturel death. 1 Yes 2 No I Director: A 2 ☐ Accident within 24 hours after de-To the Funeral Director completaty filled in by th 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

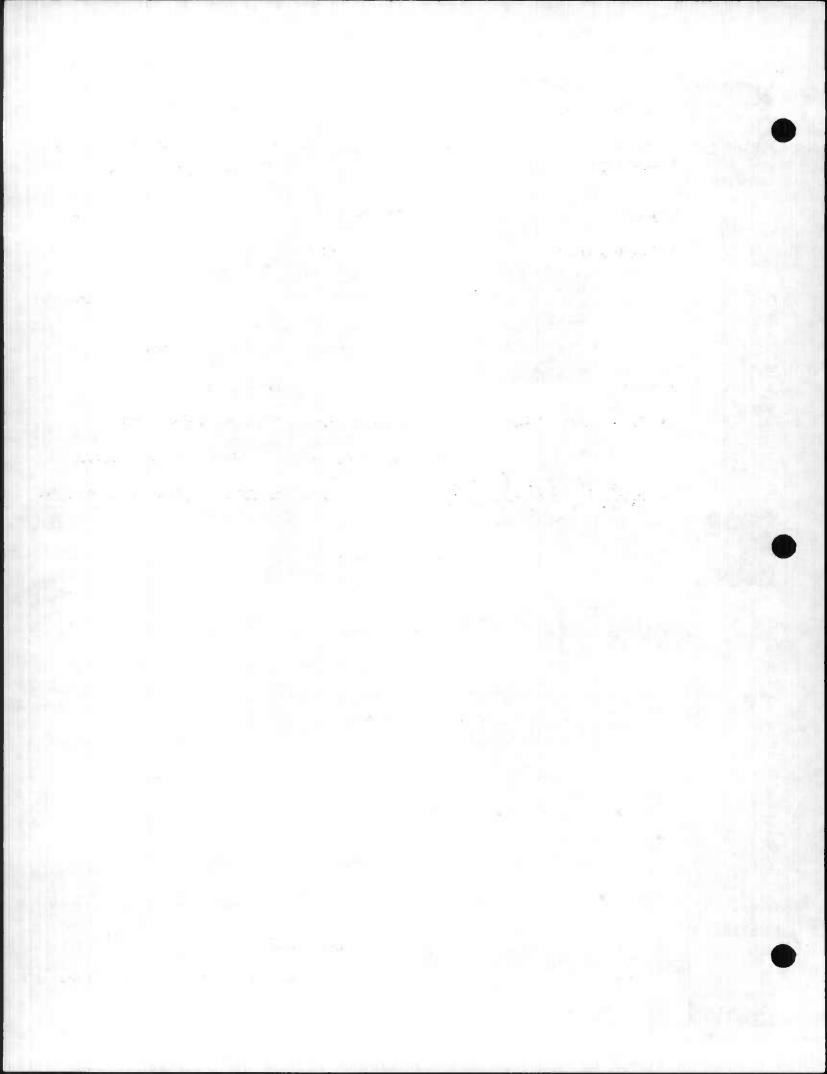
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edicai 29a. Certifier To the 29b. Signature and title of certify 29c. Licansa number 29d. Date signed (Month, Day, Year) use of deeth (Itam 23a) (Type, Print) 5602 AMS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1999 MAR 8 Registrar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, Las	st)					2. Dete of Dea Month	nth Dev	Year	3. Time of Death
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Examiner	0.00	Facility Neme (If not Institution, give				4b. (City, Town, or L	ocation of Death	4c. County	of Death	
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		ual Residence of Decedent		I an on							
ahow Market		a. Stete 10b. County /aryland n/a		10c. City,	Town or Location Baltimore	City				10	d. Inside City Lim
28s-f sho culting											
r items 23s or 28s-fs instruments collised Funeral Director	100	e. Street and Number 3742 Lyndale Avenue			101. 2	Zip Code 21213			10g. Citizen of V	What Count USA	ry?
E E	11.	Marital Status	12. Wes Decedent (Armed Forces?	Ever in U,S.	. 13. Was Dec	edent of Hispa pecify Cuben, N	anic Origin? (Sp Mexican, Puerte	pecify Yes or No- Rican, etc.)	14. Race Blec	a - America k, White, e	
o A		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 f If Yes, Give Year or Dates:			2□XNo S			Specify		White
natural,		15. Decedent's Ed (Specify only highest gra	ducation		16a. Decedent's Us (Give kind of v life. DO NOT	suel Occupatio	n na most of won	kina	16b. Kind of Bu	usiness/Indi	ustry
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Cor			2		Sign P						
g • o	3 11	Father's Name (First, Middle, Last)				18		ne (First, Middle,		10)	
matic e		laan Jarv						e Kruusko			
renu		na. Informant's Name/Relationship (Nrs. Salme A. Jarv			19b. Mailing Addre						Code)
m 27		a. Method of Disposition	(Wife)	20h Pla	3742 Lynda ca of Disposition (A		e Baiti	more, Mar	yland 212.		wn State
2	201	1 ☐ Burial 2 💢 Cremation 3 🗆		cen	netery, crematory o	r other place)		0.100			
luny in		4 □ Donetion 5 □ Other (Specify	-9	Hi I I	top Service	-		3/6/99	Towson	Maryla	and
Important: If item 27 any injury or other ti once.	21	Signature of Fugural Service Licen	V Sol	L		J. Ruck		805 Harfon	d Road Ba	alto. M	Md. 21214
	23	Ba. Part1. Enter the disease, or shock, or heert failure. List till y	cations thet caused	the death.	Do not enter the m	ode of dying, s	such es cardiac	or respiratory ar	rest,		Approximate
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siclan end buriel-trensit cal Examiner	re	sulting in death)	b.	Due to (or a	as a consequence of	hy m:1	a, lupa				5
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND: #23 PART I, PER MD G773 7-17-99 WR. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Candice Jones ebruary /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Kosec Square Hospita Cente tranklin If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1□ M 2□ F Months Days none Director 2 43 Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Modical Expressor must be notitled at Harford Maryland Edgewood Directo 10e. Street and Number 1930 Edgewater Drive Funeral

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

Never Married 2 ☐ Married

3 Widowed 4 Divorced

þ

Completed

Be

should be filed within 72 and Mental Hygiene.

Pages 1 and 2 ment of Health a met if from 27 lo

Physician

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Attending Physician:

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Division of Vital Records, P.O. Box 68760

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h Important: If any injury o once.

Landice

on	10d. Inside City Lim	nits
	1□ Yes 2뒀	No
Of. Zip Code	10g. Citizen of Whet Country?	
21040	U.S.A.	
Decedent of Hispenic Origin? (Specify) s, specify Cuban, Mexicen, Puerto Rican	es or No- etc.) 14. Raca - American Indian, Black, White, etc.	
Yes 2 No Specify:	Specify: Black	
s Usuel Occupation	16b. Kind of Business/Industry	

Reg. No.

16, 1999

16

none

Month

3. Time of Death

2 hours 43 mulos

more

Maryland

Birthplece (State or Foreign Country)

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 0 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Jones Tosha Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1930 Edtgewater Drive, Edgewood, Maryland 21040 Tosha Brown/mother 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State

13. Was

10

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 □ Donation 5 ☑ Other (Specify)in state 21. Signature of Europe Service 32 Name and Address of Fecility Board, 655 W. Baltimore Street Wado Director

Baltimore, Maryland 21201 nau s that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death one cause on each line. **IMMATURITY**

Immediate Cause (Final disease or condition resulting In deeth) emise 0 Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as a consequence of)

23b. Did tobacco ues contribute to the causs of death? Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No 1 Yss 3 Probably 4 Unknown

24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was en autopsy performed?

2 No 1 Yes 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 1 Neturel 5 Pending Investigation Injury 1 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

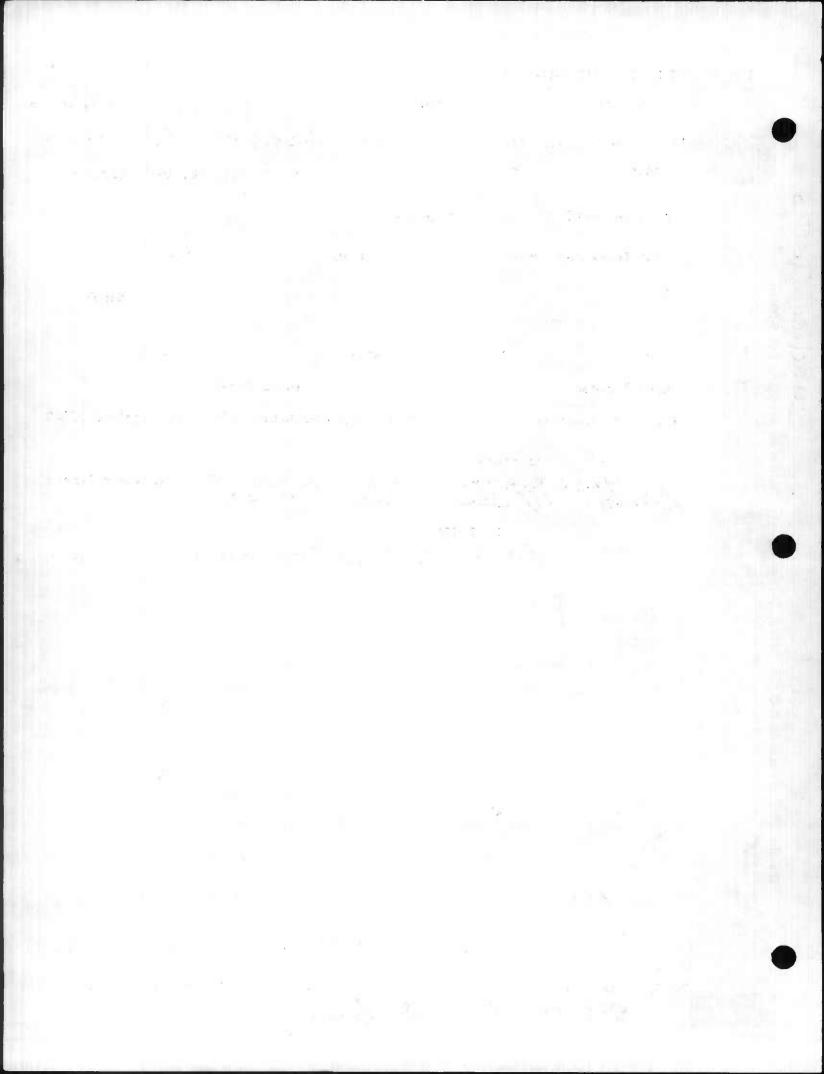
12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and menner stated. (Check only one)

29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c License number February 17,1999

30. Names and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Drive Baltimore, mp Franklin Square Salgi man Bhan MD 9000 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day 10:38 Kenned 03 99 05 urtis 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Syskin NA. 6. Sex Medical 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10M 20F 2/8 98 2503 Yrs. Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No BALLIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? W. USA 2810 Idspring Loune 21215 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No if Yes, Givé Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indien, 11. Maritai Status Bleck, White, etc. Never Merried 2 Married 1 ☐ Yes 20 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working jife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BUSINESS Private Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker grade 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) LEG KENNEDY PERRI 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2/3/5 19a. Informant's Name/Relationship (Type, Print) 2810 W. aldspring Lane Beltinon, Nary / Ans MOTHER KENNGOY 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremetion 3 ☐ Removal from State HRBUTUS 4 ☐ Donation 5 ☐ Other (Specify) Momorial Parla 22. Neme and Address of Fecility CHATRIAN-Feneral Hone 21. Signature of Funeral Service Licensee 1240 REISTERStown MAD 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as pardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximete interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Depsis Due to (or as a consequence of): AIDS Due to (or as a consequence of) Due to (or as e consequence of)

Physician /Medical Examiner

ician end burial-transit

physician s the burial

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should I

After this certificate has

To the Hospital or Attending within 24 hours efter death. To the Funeral Director: Aft completely filled in by the fur

or Attending Physician:

pega 2 s

funeral

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Completed

Be

To

Certification:

Medical

98

The law requires that the death certificate be axecuted

Box 68760,

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

Funeral

Director

r is marked other than "natural", or items 23a or 28a-f show traumatic event, tra Medical Examinar maint be notified at

72 hours after death

Hygiena.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic even PARE.

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Physician/Medical

Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy

24b. Were autopsy findings eveileble prior to completion of cause of death?

1□ Yes 2☑No

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

1 PInpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of curtified MO

29d. Date signed (Month, Dev. Year) 29c. License number 03

2120

ss of person who completed cause of death (item 23e) (Type, Print)

Hospital:

lela 12 S

Bultimore M.D. Greene

State Registrar

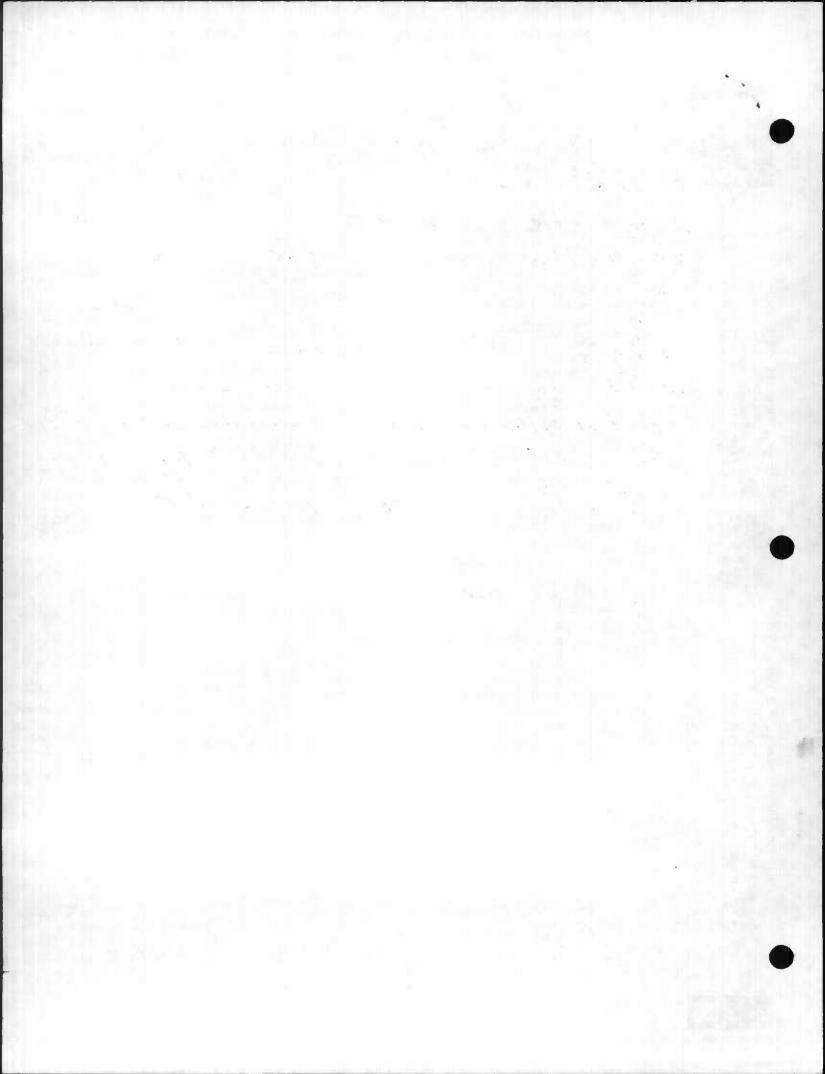
DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year) MAR 8 1999

5 Pending investigation

6 Could not be determined

32, Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month 4:16 PM **Physician** LONGDO BERNADETTE 3 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner HOSPITAL BURNIE GLEN ARUNDEL North If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foraign **Funeral** Days Months Hours 1 M XXF 79 Director 074.38.2343 1/27/1920 CANADA Usual Residence of Decedent the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at Director 1 Yas 27 No ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 7885 GORDON COURT CANADA 14. Race - American Indian, Funeral 21060 death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status a filed within 72 hours after du il Hygiene. other then "natural", or item Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XX Yo Specify. Specify: WHITE If Yes, Giva Year or Datas: p 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled wit Department of Health and Mental hygient Important: If Item 27 Is marked other that any injury or other traumatic event, that phose. NURSE **OGDENSBURG** 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be MARIE ANGE TASSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) MARK LONGDO - SON 54 FORESTDALE AVE., GLEN BURNIE, MD 21061 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Remoyal from Stata BALTIMORE, MD METRO CREMATORY 22. Nama and Addrass of Facility FT 4 Done (5 ☐ Other (Specify) 3/8 FINK FUNERAL HOME, P.A. and Service Lion 426 CRAIN HWY. S.W. GLEN BURNIE, MD 21061 KELLY GREGORY FINK or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata Intarval Between Onset and Death **Physician** BSTRUCTIVE PULMONAR /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Examiner that the death certificate be assouted physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 887 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by i 1 Ves 2 No 3 Probably 4 Unknown USHINGOID þ bloods DEPENDENT 24a. Was an autopsy performed? Were autopsy findings available prior to Completed completion of cause of deeth? paga 2 has 1 Yas 2 1No 1 Yes 2 LNG Division of Vital or Attanding Physician: Be 25. Was casa refarred to medical axaminer? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No edical Certification: To this After this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 De Netural 5 Pending To the Hospital or Attanding within 24 hours after death.

To the Funeral Diractor: Afte completely filled in by the fun 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At homa, farm, atreet, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

29b. Signatura and title of ce

31. Data filed (Month

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

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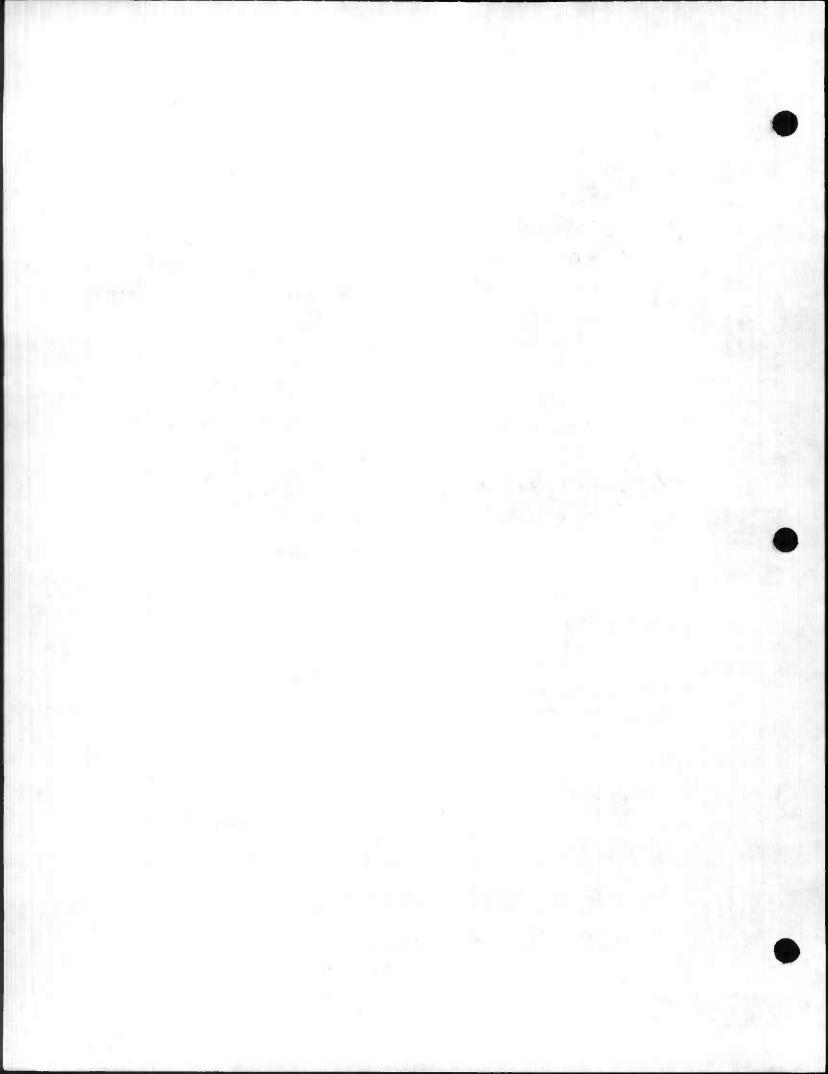
32. Registrar's Signatura

DHMH 16 Rev 6/95

29c. License number

rain Towers

29d. Data aigned (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death 2 40km LEWIS HERBERT 1999 MAR CH 4c. County of Death 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death BON SECOUNS 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth 5. Social Sacurity Number 6. Sax 8. Data of Birth (Month, Day, Year) 3-11-192 Birthpleca (State or Foreign Country) 1 M 2□ F Months Days Min. 239-36-8024 Usual Rasidenca of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Baltimore 1 Yas 2 No Md 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 509 Allen Glen U.S 21229 12. Was Dacedant Evar in U,S.
Armed Forcas?
1 ☐ Yas 2 D No
If Yas, Giva
Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Raca - Amarican Indian 1 Navar Married 2 Marriad 1 Yas 2 No Black Specify: 3 Widowad 4 Divorcad 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedent's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) Company 1-enang Elemantary/Secondary (0-12) Collaga (1-4or 5+) UNK haboner unk 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Meiden Surnama) Kobert hewis Hennetta Howard 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 1980 2 19e Informant's Name/Relationship (Type, Print) Chald Street Wilming Son DE 20c. Location - City or Town, State hewis 20b. Place of Disposition (Name of camatary, cramatory or other) 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata Chapel Centery East Arcadia, 4 □ Donation 5 □ Othar (Spacify) Graham 21. Signatura of Funaral Sprvice Licensee 22, Nama and Addrass of Facility Manh F. H. West ask See Aver Approximata intarval Batween Onsat and Death Immedieta Causa (Final CEREBRO VASCULAR ACCIDENT disaasa or condition rasulting in daath) Dua to (or as a consequenca of) Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Ceusa (Disaasa or Injury that Initieted avents rasulting in deeth) Last Dua to (or as a consequence of) Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ERTENSION 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performad? 1 Yes 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminer? 26. Place of Death (Chack only one) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yes 2 No 1 Thpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannarof Deeth 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 1. Natural 5 Panding Invastigation 2 Accidant 1 Yas 2 No 6 Could not be datermined 3 Suicida 28a. Placa of injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 - Homicide 1 Certifying Phyaician: To the best of my knowladga, daath occurred et the time, dete end placa, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On tha basis of axamination end/or investigation, in my opinion, daath occurred at the time, date end place, end due to the ceusa(s) and manner statad. 29e. Cartifia: (Check only one)

Box 68760 P.O. Division of Vital Records. To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: After

Physician

/Medicai

Examiner

Director

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Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer. Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or then any injury or other traumatic event.

Physician /Medical

Examiner

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After this

Physician/Medical

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Certification:

Medical

Baltimore, Maryland 21215-0020

death with the Meryland

Registrar

31. Data filed (Month, Dey, Year) MAR 8 1999

30. Nema and addrass of parson who completed cause of deeth (Itam 23a) (Type, Print)

MILLER

29b. Signature and titla of cartifiar

32. Ragistrar's Signatura

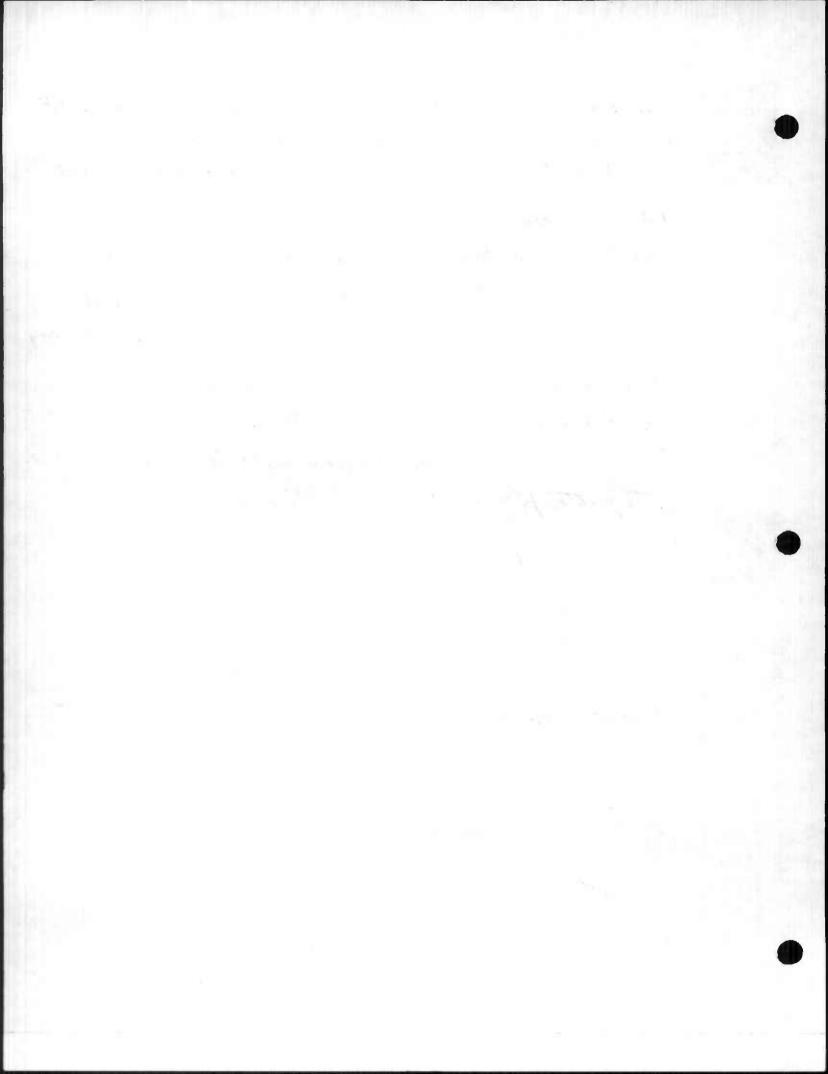
BON St Cours

29c. Licansa numbar

302 72

HOSPITAL

29d. Data signed (Month, Day, Yaar)



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Certificate of Death	Reg. No.				
ate of Maryland / Department of Health and M	Mental Hygiene 9	07		3	O
COLLINE III DIGCK III GEIDIC IIIK. ASSUIC A				-	_

BALTIMORE

Physician	
/Medical	ļ.
Examiner	ľ

Lovelace John

FEBRUARY 27, 1999 4b. City, Town, or Location of Death 4c. County of Death

11:09 AM

Funeral Director

death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at Director Funerai Pages 1 and 2 should be filed within 72 hours after chant of Health and Mental Hybjane.
Int: If flem 27 is marked other than "natural", or flee ury or other traumatic event, the Medical Example. p Completed

Be 10

Baltimore, Maryland 21215-0020

permit. Pages Department of Important: If in any Injury or o

Physician

/Medical Examiner

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s after de---I Director: After --v the fr

24 hours

within 24 hor To the Fune completely fi

Hospital or Attending Physician:

ģ

Completed

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Certification:

edical

the death certificate be executed

Division of Vital Records, P.O. Box 68760,

4a Facility Name (If not institution, give street end number) 4529 PIMLICO ROAD 5. Social Security Number 213-28-1484 Usuel Residence of Decedent

10b County

1. Decedent's Name (First, Middle, Last)

7. Age (In yrs. last birthday) 1 M 2 F 63

If Under 1 Year | If Under 24 Hrs. Months Days Hours Min

8. Date of Birth (Month, Dey, Year) 35 05 15

 Birthplace (State or Foreign Country) V.A

Md

10a State

Baltimore

Yrs.

10c. City. Town or Location

10d. Inside City Limits XXYes 2 □ No

10e. Street and Number

3019 Rosalind Ave 1' Never Married 2 ☐ Married

NA

12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates

21215 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1□ Yes 2XNo

U.S.A. 14. Race - American Indian. Black, White, etc.

10g. Citizen of What Country?

Specify:

Black 16b Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade

3 Widowed 4 Divorced

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

10f. Zip Code

17. Father's Name (First, Middle, Last)

Construction Worker 18. Mother's Name (First, Middle, Maiden Sumeme)

Gas & Electric Co

Allen Lovelace

19a. Informant's Name/Relationship (Type, Print)

Cennie Bradley 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)

Evelyn Manley-Sister 20a. Method of Disposition

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

21215 Baltimore Md 20c. Location - City or Town, State

1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee

Garrison Forest Vet 22. Name and Address of Facility

March F/H West

3019 Rosalind Ave,

3/9/99 Owings Mills, Md

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

21215 Approximate Interval Between Onset and Death

immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Physician/Medicai

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were eutopsy findings available prior to completion of cause of death?

2 \ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No 27. Manner of Deeth

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 5 Pending Investigation

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

26. Place of Death (Check only one)

29a. Certifier (Check only one)

1 Matural

3 Suicide

2 Accident

4 | Homicide

1 Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. License number OCME

29d. Date signed (Month, Dey, Year) FEBRUARY 28, 1999

eodu. 30. Name and eddress of person who completed cause of beath (item 23e) (Type, Print)

THEODORE M.K.

6 Could not be determined

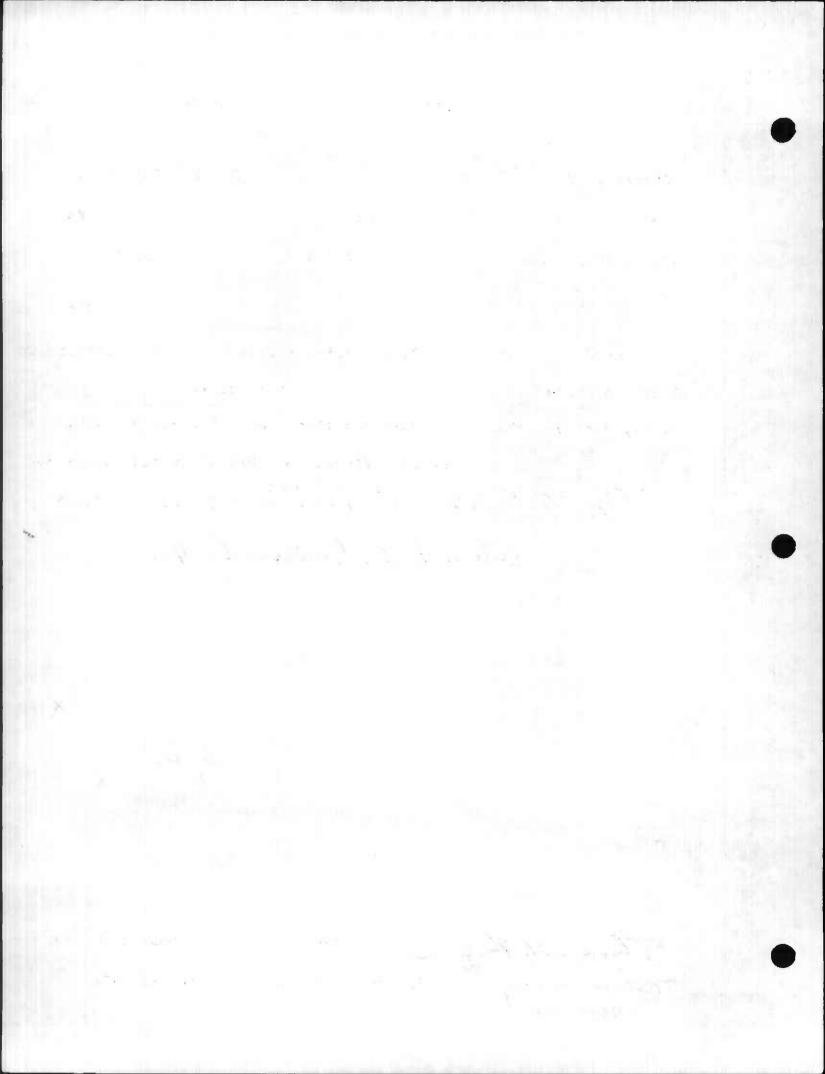
111 Penn Street, Baltimore, Maryland 21201

31. Dete filed (Month, Day, Year) MAR 8

2. Registrar's Signature 1999 13/1

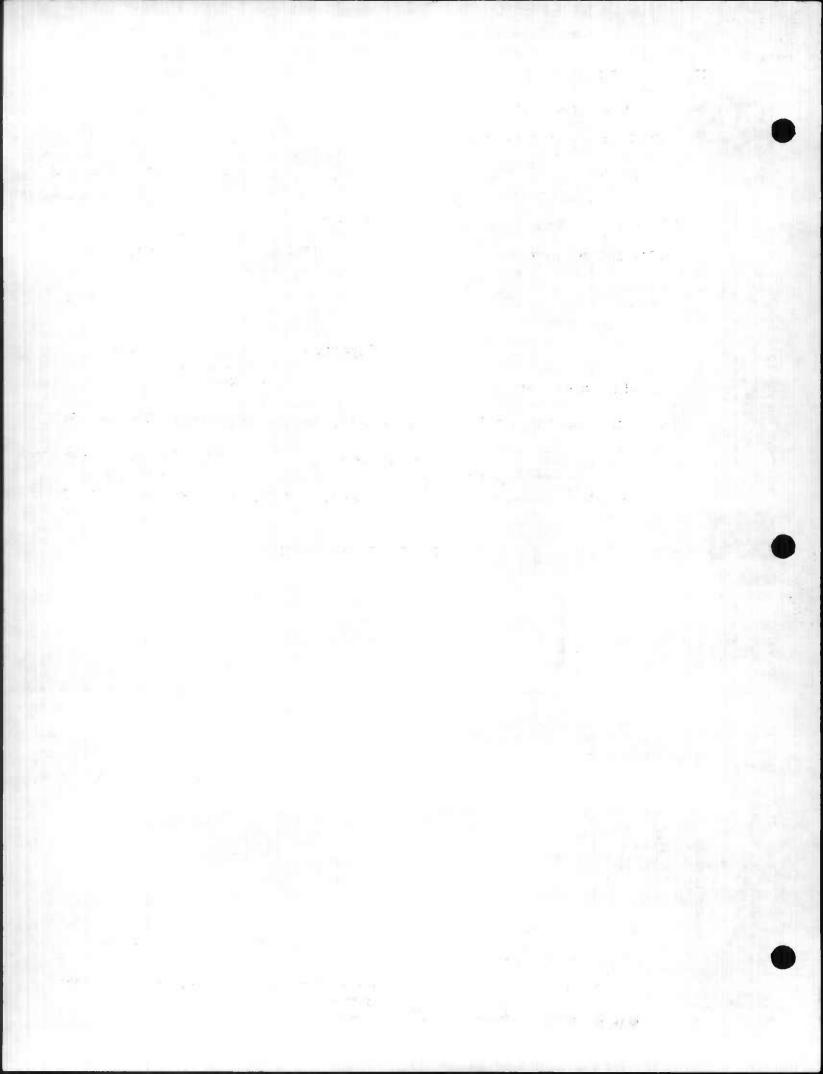
Registrar

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

IT	TEN	1S: #23 PART	I, 27 P	ER MEO G76	9 3-23-	99 WR. Cel	tificate of	Death		Reg. No.		3. Time of Death
Physician	_	1. Decedent's Name (First, Middle, Last) Amber Ann Leon							2. Date of De Month March	Day	Year	2:02 P.M.
/Medical	_	AIIDE			mber)			4b. City, Town, or				Z.UZ F.FI
Examiner	۲.			n Hospit				Balti		N/Z		
Funeral		5. Social Security Num		S. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		th Vacal	9. Birthpla	ce (State or Foreig
Director		217-53-460		1□M 2 X 0F		O Yrs.	Months Days	Hours Min.	Nov. 4	, 1998	Mar	yland
show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								100	d. Inside City Limits		
ith with the Maryla 23e or 28e-f should be notified at	2	Maryland	1	I/A		В	altimore					1 Yes 2□No
vith the Ma t or 28s-f s be notified	20	10a. Street and Number	er				10f. Zip Code	11.00		10g. Citizen of \	What Countr	y?
th will	2	2712 Shi	irey	Avenue			2	21214		Uni	ted S	tates
r items		11. Marital Status 1 X Never Married		12. Was Dec Armed Fo d 1 Yes If Yes, Gir	edent Ever orces? 2 (A) No ve		Vas Decedent of I I Yes, specify Cub I □ Yes 2 1 No	Hispanic Origin? (S an, Mexicen, Puert Specify:	pecify Yes or No o Rican, etc.)	9- 14. Rac Blac Specifi	ck, White, et	tc.
ural', o	5	3 Widowed 4		Year or D	ates:						WI	hite
. 30	2	15 (Specify	 Decedent's only highest 	Education grade completed)		16a. Deced	lent's Usual Occup kind of work done	pation during most of world)	rking	16b. Kind of B	usiness/Indu	istry
Hygiene. The then and, I've the	d d	Elementary/Seconds	ary (0-12)	Coilege (1-4or 5+)	me.	Depende				N/A	
and Mental Is marked o aumatic eve	3	17. Father's Name (Fir	rst, Middle, Li	nst)			Веропа	18. Mother's Nar	ne (First, Middle	, Maiden Suman		
	0	Timothy	Alan	Leon				Joan	Gambe	r		
	-	19a. Informant's Name				19b. Mailir	g Address (Street	and Number or Ru	ıral Route Numb	er, City or Town,	State, Zip C	Code)
alth a salth a n 27 ls		Joan Gambe	er Wal	drop / M	other	271	2 Shirey	Avenue	Baltim	ore, Mar	yland	21214
Department of Health Important: If Item 27 is any injury or other tr ance.	1	20a. Method of Dispos	ition		20	b. Piaca of Dispo			Date	20c. Location	City or Tow	m, State
		1 ☑ Buriai 2 ☐ C 4 ☐ Donation 5 [State		n Cemete		3/09/99	Balti	more,	Maryland
Department Important: I any Injury o		21. Signature of Funer	ral Servica LI	. Canon			. Name and Addre		INC	5305 Baltimo		rd Road ID 21214
-	+	23a. Part1. Enter the o shock, or heart fa	disease, or c		1	death. Do not ent		· ·				Approximate Interval Between
Medical Manual M		Immediate Cause (Fin disease or condition resulting in death)		a	Due	to (or as a consec		OME (SIDS)				
ficate be executed physician and is the bunal-transit edical Examir	EYall	Sequentially list conditions in any, leading to immediate. Enter Underlyi Cause (Disease or Injuries)	tions, ediate ing		Due	to (or as a consec	uence of):					
	2	that initiated events resulting in death) Las		d	Due t	o (or as a conseq	uence of):					
at the death certified by the ettending leteched for use as Physician/Me	5							1 9 .1	ant Divi	A-A		the cause of death
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within 24 To the Fu		29b. Signature and title	e of ceptifier	Vilg man	statett.		29c. Licen	se number		29d. Date signe	ed (Month, D	Pay, Year)
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		30. Name and address	WWD W	o completed caus	se of death			Street, E	Baltimor	e, Mary	land 2	21201
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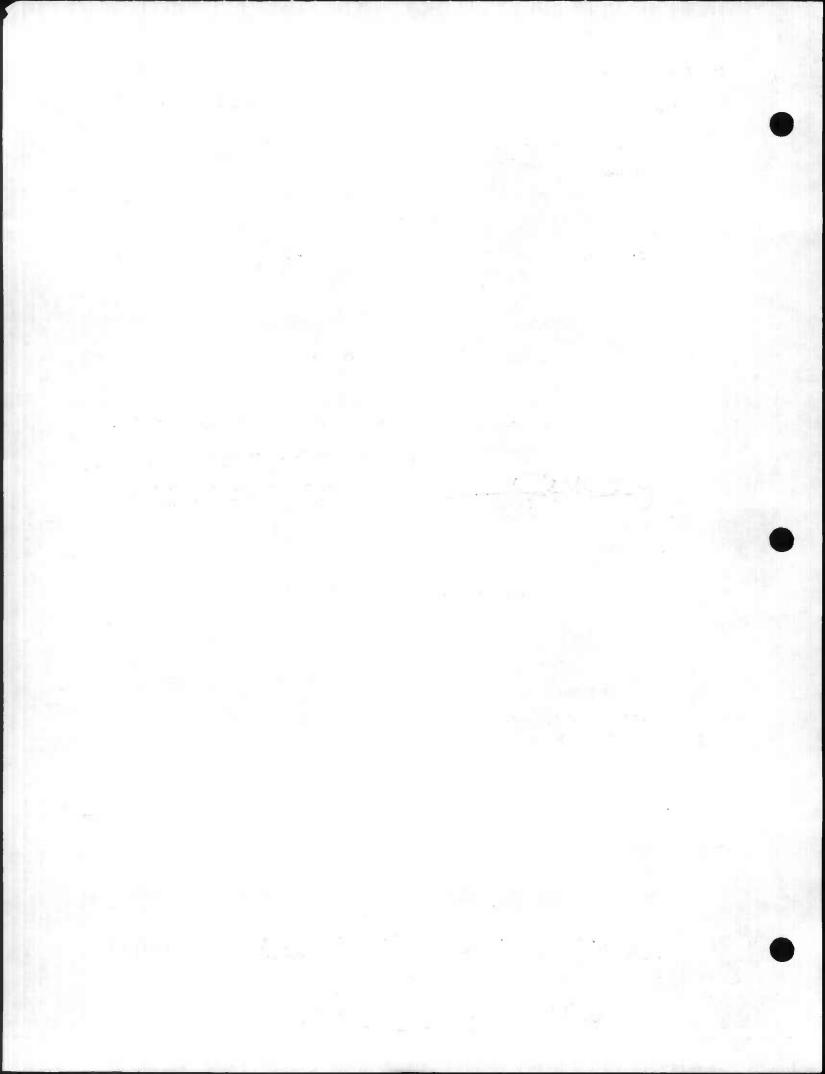


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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Item#7 perFH G769 3/8/99 EW 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Vear **Physician** Soon Yi 5, 1999 March 11:35PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 615 Cranbrook Road Apt. Cockeysville Baltimore H Under 1 Veer 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 F Months Hours 91 Yrs. 90 Director Dec. 14, 1908 212-17-0994 Korea Usual Residence of Decedent with the Maryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director MD Baltimore Timonium 10e Street and Number 10g. Citizen of What Country? 10f. Zin Code 2205 Spring Lake Drive 21093 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

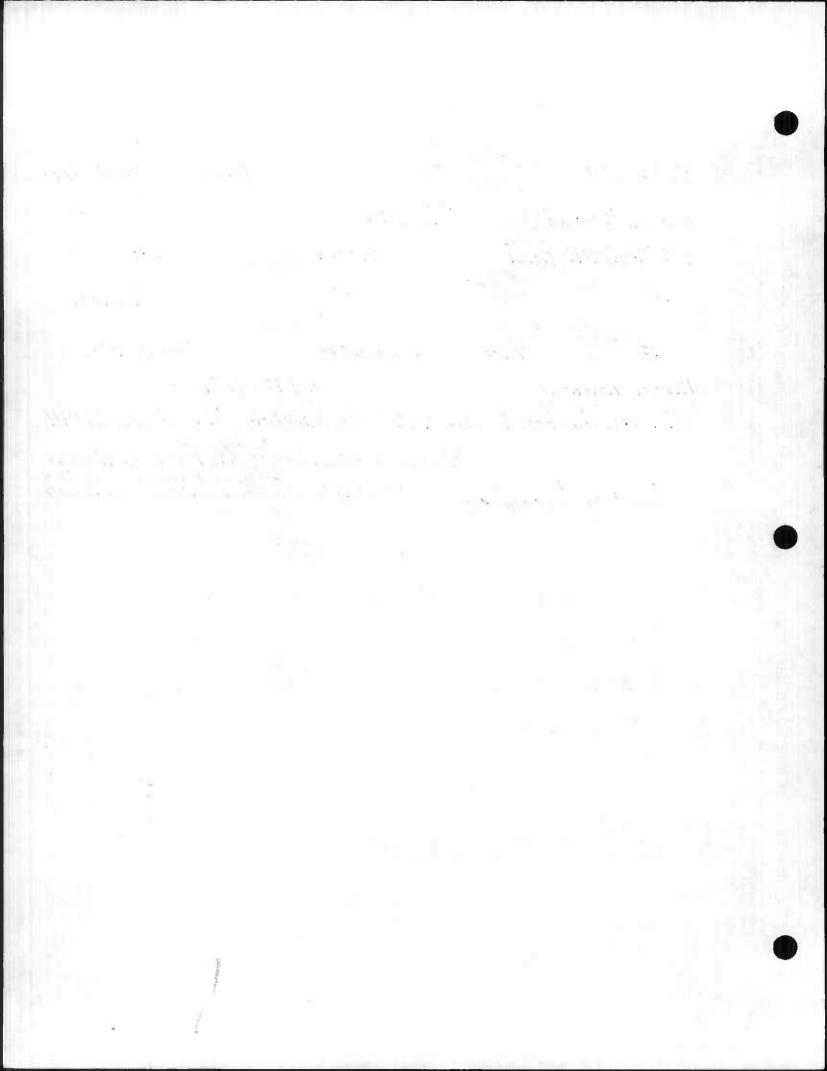
1 ☐ Yes 22 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P Korean 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel hygiere. Important: If Itam 27 is marked other than "reany injury or other traumatic avent, the Health and Injury or other traumatic avent, the H Elementery/Secondery (0-12) College (1-4or 5+) 8 N/A Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bog Duk Lee unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Hyesin William/Granddaughter 2205 Spring Lake Drive Timonium, MD 21093 20b. Place of Disposition (Name of cametery, cremetory or other place)
Dulaney Valley Memorial 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State March 9, 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Timonium, MD Gardens 21. Signature of Funeral Servi 22. Name and Address of Fecility Lemmon Funeral Home of Dulaney Valley, Inc. 53 Flagle (Michael 10 W. Padonia Road Timonium, MD 21093 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or hear failure. List only one cause on each line. Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Hypovolemic Shock 1 Hr. Examiner Due to (or es e consequence of): Gastrointestinal Bleeding 6 Hrs. Examin Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 950 ed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 20 No 3 Probably 4 Unknown Cardiac Arrhythmia Division of Vital Records, by 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes an autopsy performed? Completed has 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medicel Be 26. Place of Deeth (Check only one) Daughter's Other: 4 Nursing Home 5 Residence 6 Nother (Specify)Home. Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 27. Menner of Death 1 Neturel 28a. Dete of Injury (Month, Dey Year) 28c. tnjury et Work? 28d. Describe how injury occurred 28b. Time of Certification: Attending 5 Pending Investigation Injury i or Attendin effer death. I Director: Aft d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and menner as stated.

Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. onel 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature nd title of certifier and address of person who completed cause of deeth (Item 23a) (Type, Print) FRANCESCO GRASSO MD, 6569 N. CHARLES SI TOWSON MD 21204 31. Dete filed (Month, Dey, Year) 32. Register's Signeture MAR 8 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death Month 1. Decedent'a Name (First, Middle, Last) 3. Tima of Death Year **Physician** Vel 7:02 AM 1999 MAYON /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner vino Columbia Howard beneval Lospita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 10 M 20 F 88 Yrs. Director Mississippi 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-1 show 1PTes 2□No Director Maryland Howard lumbia 10g. Citizen of What Country? 10f. Zip Code 925 Ten 21044 USA Funeral Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status filed within 72 hours efter 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2₽No specify: Black Specify þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MA Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be fi Department of Health and Mental F Important: if Itam 27 is marked of any Injury or other traumatic availables. Pages 1 and 2 should be nent of Health end Mentai Albert Hddie 0 Anthony V1150n 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mills Rd. MD.21044 yton-Daughter 4925 Ten 200. Place of Disposition (Name of Sharon Gu (O/L) mbia 1ch 20a. Method of Disposition

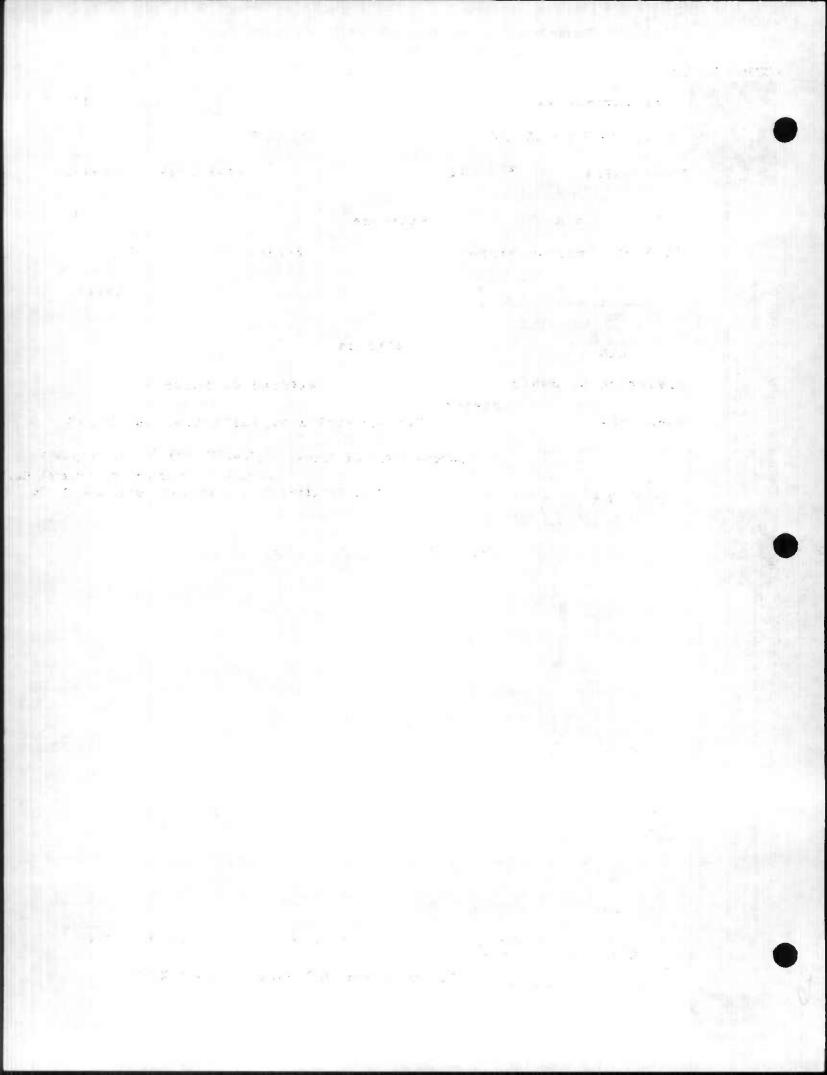
1 Burial 2 Cremetion 3 Removel from Stete - City or Town, Stete Date cemetery, cremetory or other place, march Flint Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Douglass Funeral Service 21. Signeture of Funeral Service Licenses 1701 Mc Culloh St. Baltimore, MO.21217 ariton ons thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, ause on each line. Approximate Interval Between Onset and Deeth 23a. Part1. Enter the disease, or shock, or heart failure. List **Physician** /Medicai Immediata Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner ne monia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intieted events resulting in death) Last Due to (or es a consequence of) or Attending Physician: The law requires that the death certificate be seen Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 Yes 2 No Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Ulcer Disease 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ EN Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director: After this 28a. Dete of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Netural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospital edical 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the lime, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mona 200 52165 MArch 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Drive, Columbia, Maryland Beil 2 Knoll worth Kamona Rer 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 8 Registrar



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To the Funeral Director: Af

Physician

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Examiner

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permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien, important: If Item 27 is marked other that eny injury or other trauments.

Baitimore, Maryland 21215-0020

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Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 25. Was case referred to medical 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 5 Pending invastigation 1 Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifier ES Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0051552

29d. Date signed (Month, Day, Year)

March

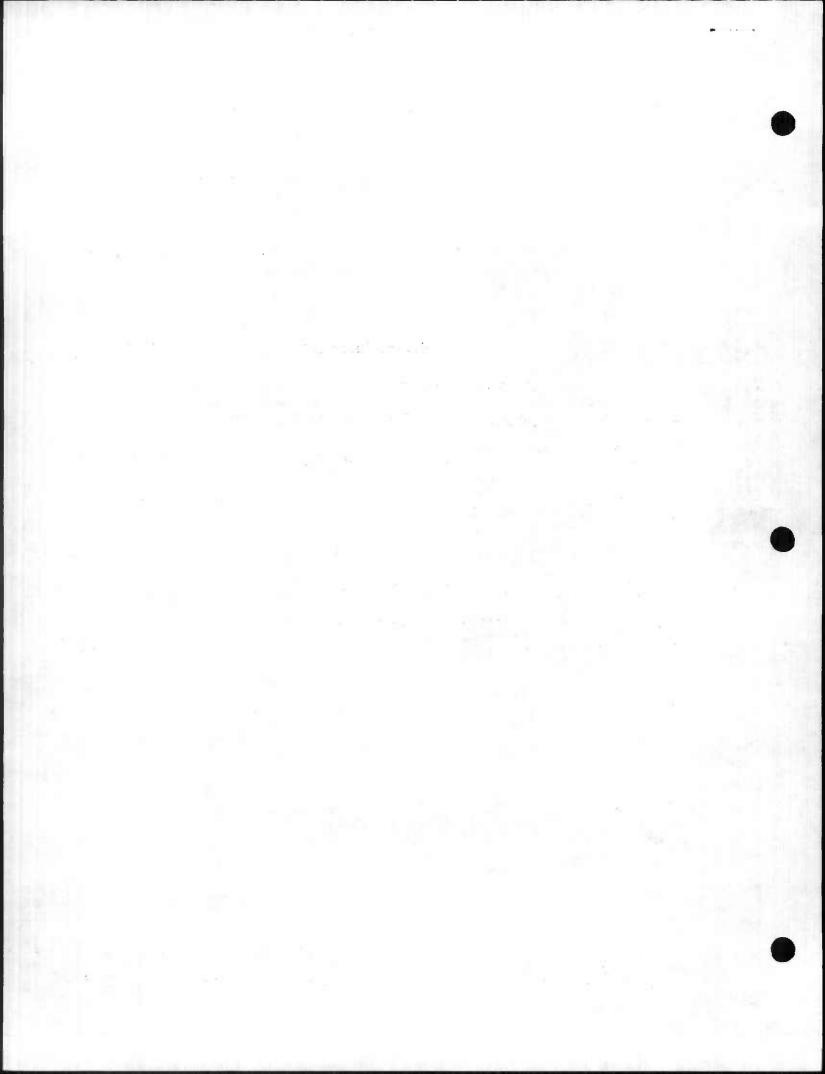
State Registrar

edical

29b. Signature and title of certifier

31. Date filed (Mostly, Day, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Owings Mills, Haryland 21117



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Item: 10d per F.H G-769 3/8/99 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:10 An Rebecca Sosa OSP 1999 Mar Sister Mary /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Baltimore St. Agnes Hospital If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Yrs Director 220-58-1494 92 08-31-06 Cuba Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at TO Tes 2XX No Baltimore (Catonsville) MD Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21227 Cuba 701 Gun Road Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. d 2 should be filed within 72 hours efter the end Mental Hygiene.
77 Is marked other than "natural", or file traumatic event, tra Medical Evantine. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 KYes 2 No Specify: Cuban Specify: Hispanic þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Religious Elementery/Secondery (0-12) College (1-4or 5+) Dietician Secondary Congregation 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden St Be Jose Sosa Dolores Carnesoltas 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Department of Heelth and Important: If Item 27 is m any Injury or other traum pncs. Sister M. Alexis Fisher, QSP 701 Gun Road, Baltimore, Md 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Maurial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 3/9/99 Baltimore, Md 22. Name and Address of Fecility
March F/H West
4300 Wabash Ave, Baltimore Md 21215 ar 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical neumonia week Examiner Due to (or es e consequence of) Examiner iclen end buriel-trens Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physiclen s the burie 68760 Physician/Medical Due to (or es a consequence of): 98 950 deteched Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilable prior to completion of ceuse of death? Completed 24a. Was an eutopsy performed? certificate hes 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medicel examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? 5 Pending investigetion 1 Neturei s efter death. 1 TYes 2 □ No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 24 hours 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.
2 Madicai Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner steted. 29e. Certifier Medicai To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) MD Ka nka-le D46704 1999 30. Name end eddress of person who completed cause of death (item 23e) (Type, Print) 900 s. Caron Street Hanes Hospital

32. Registrer's Signature

1999

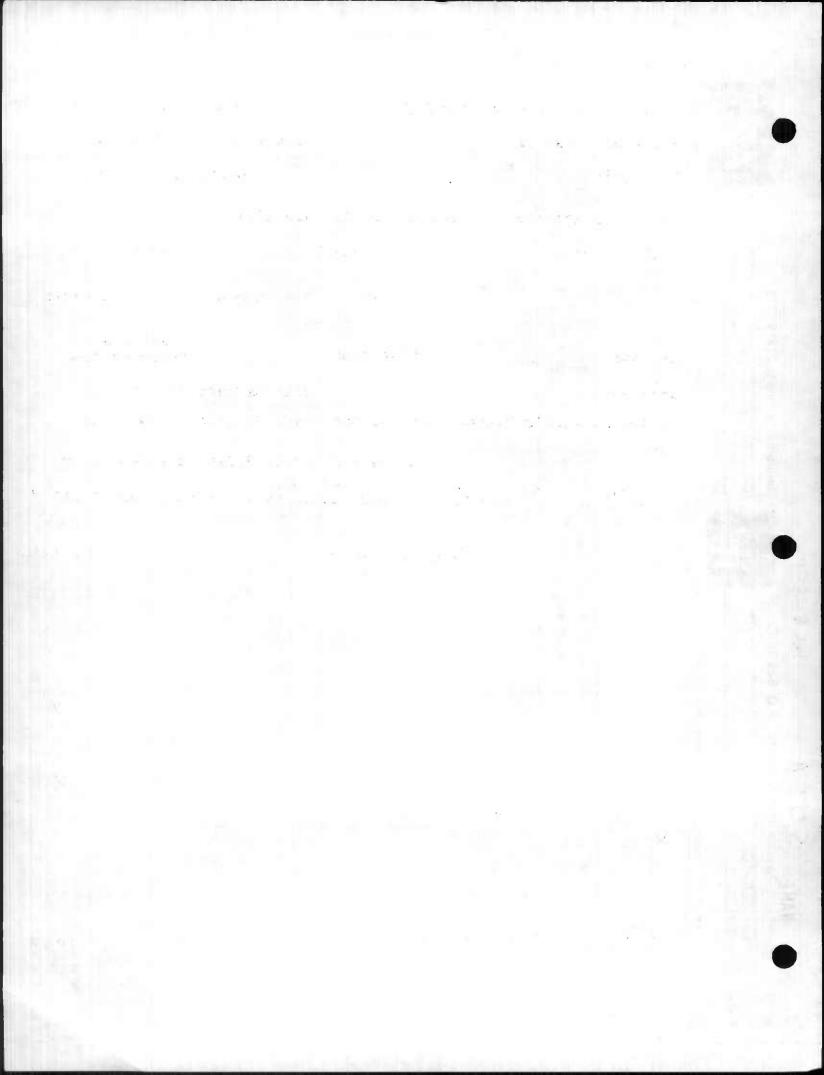
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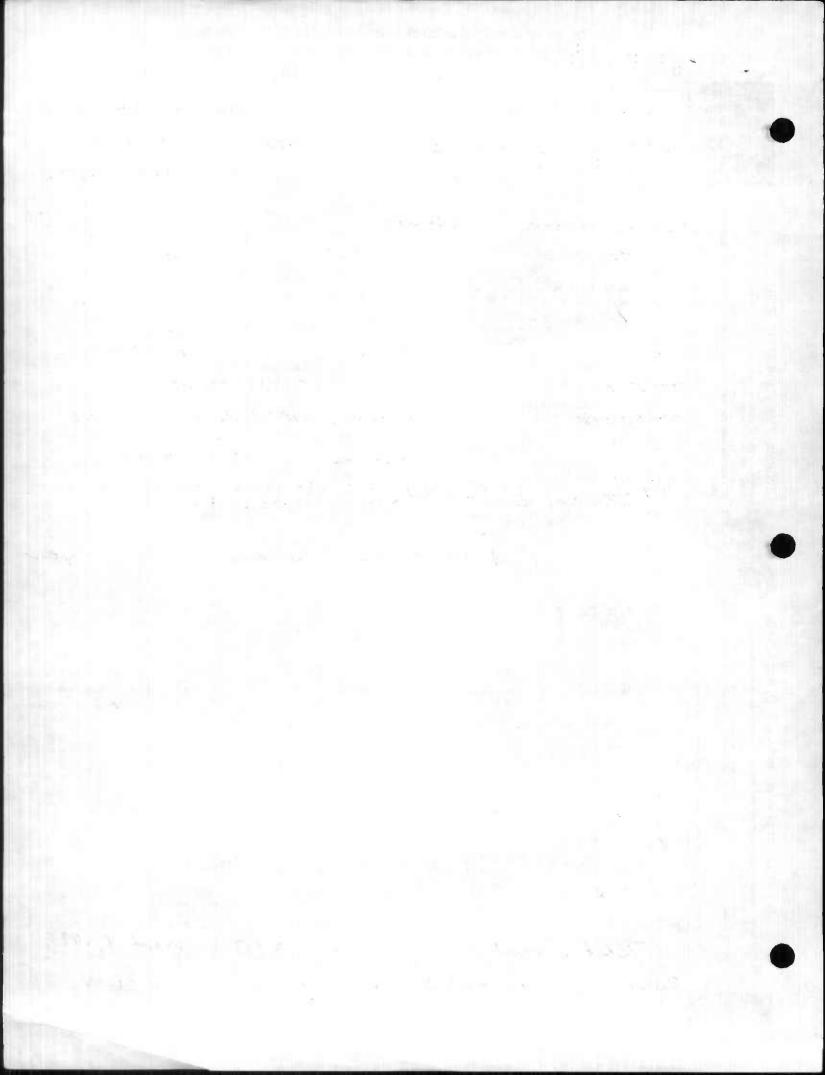
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: #5 PER G7 State of Maryland / Department of Health and Mental Hygiene Item: 16b per F.H G-769 3/8/99 reb Certificate of Death Certificate of Death Reg. No." 3. Time of Death 1. Decedent's Name (First Middle, Last) 2. Dete of Deeth Day **Physician** Francis J. Olszewski MARCH 04 1999 02:20AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner GREATER BALTIMORE MEDICAL CENTER
Social Security Number 6. Sex 7. Age (In yrs. lest birthday) TOWSON
If Under 24 Hrs. BALTIMORE If Under 1 Yeer Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1**■** M 2□ F Days Hours Min Yrs. 214-22-1670 Director Nov.06,1929 Maryland 69 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "natural", or Itama 23a or 28a-f ahov traumatic avent, tra Modical Examinat must be notified at 1 ☐ Yes 2 No Directo Baltimore Maryland BALTIMORE

10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 1933 Stanhope Road Funeral 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify by 3 ₩ Widowed 4 Divorced White OLSZEWSKI, Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry BETHLEHAM Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) Machinist Bethlehelm-Steel 10th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Department of Haalth and Mantal Important: If them 27 is marked of any injury or other traumatic even Pages 1 and 2 should be Frank Olszewski Cecelia Olszewski 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 1933 Stanhope Road Baltimore, MAryland 21222 John Olszewski/Son 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 3/6/99 Most Sacred Heart Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Neme end Address of Fecility David J. Weber Funeral Homes, P.A. 401 S Chester 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) 1841 Examiner Due to (or es e consequence of) Physician/Medical Examine attending physician and for use as the bunal-transit that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events Due to (or es e consequença of) Due to (or es e consequence of): resulting in deeth) Lest as signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings eveileble prior to 24e. Was an autopsy performed? Completed peen completion of cause of death? aw i has The 2 No 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) To Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manner of Deeth 28d. Describe how Injury occurred After t Certification: 28b. Time of 28c. Injury at Work? or Attending 1 Neturel 2 Accident 5 Pending Investigation r death. 1 Yes 2 No Diractor: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) An Anna Marke Funeral Dirac 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 1💋 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. vithin 2 To the 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certified 29c. License number 2810 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert 5 Lepard
31. Dete filed (Month, Dey, Jear) 6569 Street Baltomare, MD 21204 Charles 32. Registrer's Signeture 1999 12/1a MAR 8 Registrar

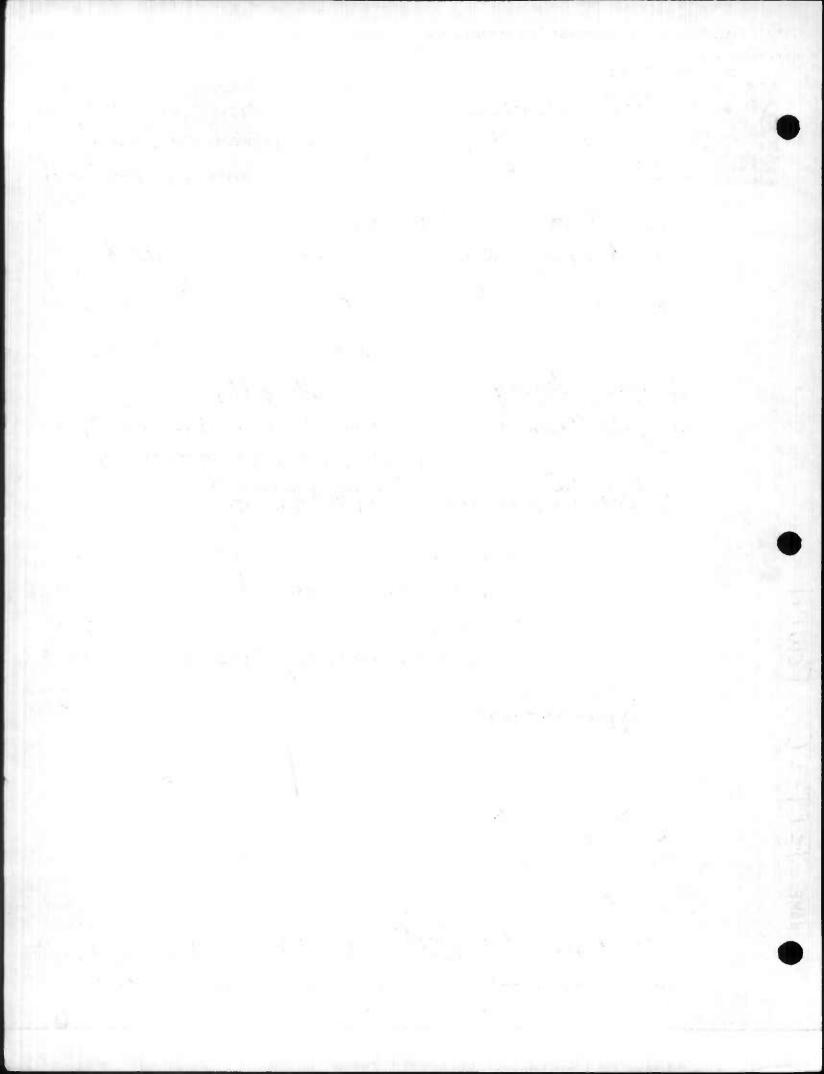


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 Item#5 perFHG769 3/10/99EW Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Dete of Death 3. Tima of Deeth **Physician** February 26 /Medical 4b. City, Town, or Location of Deeth 4e. Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** 301 Hours Min. 8. Dete of Birth March 3, 1910 Agnes Hospita 1301 l If Under 1 Yeer 7. Age (In yrs. last birthday) Birthplece (State or Foreign
 Country) **Funeral** Months Deys 1 M 2 F 88 Yrs. **Director** Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Med cal Examiner traint to notified at 1 Yes 2 No Balto atons VI Directo 10e. Street end Numb 10g. Citizen of Whet Country? 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U.S. Armed Forces? Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give / Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 25 No Specify: Black by 3 XWidowed 4 □ Divorced Completed permit. Pages 1 and 2 should be filed within 72. Depertment of Health and Mantal Hygiane. Important: if item 27 is merked other than "nett any injury or other traumatic event, the Medical 2016. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT, use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk leaning 12 17. Fether's Neme (First, Middle, Last, 18. Mother's Neme (First, Middle, Meiden Surneme) yasse 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number of Rural Route/Number, City or Town, Stete, Zip Code) daughter 20b. Place of Disposition (Name of commetery, cremetory or other place) lacque/ine 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1emorial 21. Signature of Funeral Service Coense and Address une ral 23e. Part1. Entar the disease, or complications the caused the deeth. Do not enter the mode of shock, or heart feitura. List only one cause on each line. 1701 classon Approximete Intervel Between Onset end Death dying, such as cardiac or respiratory arrest **Physician** fmmediete Ceusa (Final disease or condition rasulting in deeth) /Medical Preunonia Examiner Physician/Medical Examiner -Intarc yeous Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Due to (or es e consequence of): Vear Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably WUnknown Completed by 24b. Wara autopsy findings eveileble prior to completion of cause of daeth? 24e. Wes en eutopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Natural deeth. 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 Could not be datermined within 24 hours efter de To the Funeral Directo completely filled in by th 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Scrtifying Physician: To the best of my knowledga, deeth occurred et the time, date end plece, end due to the causa(s) end menner es steted.

Medical Examiner: On the best of axemination and/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the causa(s) end mennar statad. 29a. Certifier (Check only one) 29b. Signature and little of pertities 29c. License number 29d. Date signed (Month, Dey, Year) daeth (Item 23e) (Type, Print) Caton Avenue Michael Balt more, Shawn 31. Dete filed (Month, 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar



Funer Direct

9:35 а.ш.

March 2, 1999

CARL POLLEN

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Deperment of Heath and Mental Hygiene.
Important: If lean 27 is marked other than "natural", or items 23a or 28a-f show
any Injury or other treumatic event, are Medical Examiner must be notified at

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

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29b. Signeture and title partifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093		28e. Plece of libuilding,	njury - At hon etc. (Specify)	ne, farm, str	eet, fectory, office	8			lumber or Rui	al Route Number,
D43725 8/2/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093	Check only 2 Medical Ex	caminer: On the basis	of examinetic	ledge, deeth on end/or inv	occurred et the ti vestigation, in my	me, dete end ple opinion, deeth o	ca, end due to the courred et the time	he ceuse(s) en le, date end pl	d menner es : ece, end due !	steted. to the ceuse(s)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ROLAND M. RIDGEWAY, SR. 9:00 Am 1999 MARCH 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTH ARUNDEL Len Burne MUnder 24 Hrs. 8. Date of Birth ANNE HOSPITAL ARUN DEL 8. Date of Birth (Month, Day, Year) 9/25/1920 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Social Security Number Months Days 100 X 20 F Hours MARYLAND 218.01.8558 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ANNE ARUNDEL 1 Yes 2000 GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 533 MUNROE CIRCLE 21061 12. Was Decedent Ever in U,S. Armed Forces? ▼10 Yes 2 □ No H Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XX Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEEL FABRICATOR CATHEL BROS. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) KATHERINE A. GOUNTRUM MORDECAI H. RIDGEWAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY RIDGEWAY - WIFE 533 MUNROE CIR., GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Wurial 2 Cremation 3 R GLEN BURNIE, MD 4 Donation Other (Specify) GLEN HAVEN MEM. PK. 3.8.99 22. Name and Address of Facility FINK FUNERAL HOME, P.A. 426 CRAIN HWY. S.W. GLEN BURNIE, MARYLAND 21061 KELLY GREGORY FINK GLEN BURNTE, MARYLAND 21061 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EPTICEMI 3 days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide

The law requires that the death certificate be executed Box 68760. P.O. of Vital Records. or Attending Physician: Division To the Hospital or Attank within 24 hours after deat To the Funeral Director:

State

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

Maryland 21215-0020

DEEWRY

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mentel Hyglens. Important: if New 27 Is marked other than "netu page.

Physician

Examiner

physician and the burial-transit

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After this cartificate has

death.

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Examiner

Physician/Medical

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Be Completed

Certification: To

edical

29a. Certifier

(Check only one)

Name and add

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 8

Can

/Medical

Registrar

DHMH 16 Rev 6/95

MAD

32/Registra's Signature

ddress of person who completed cause of death (Item 23a) (Type, Print)

Activity: 301 Hospital Drive

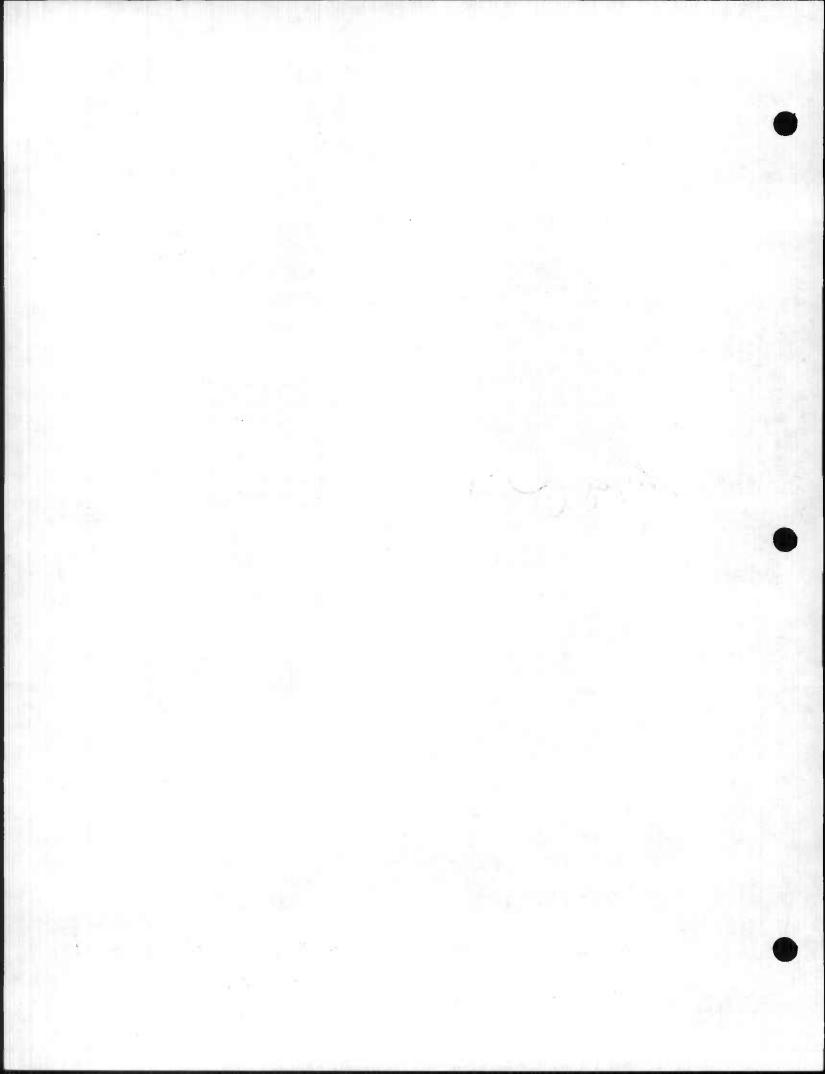
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

Brne. ms. 21061

29d. Date signed (Month, Day, Year)

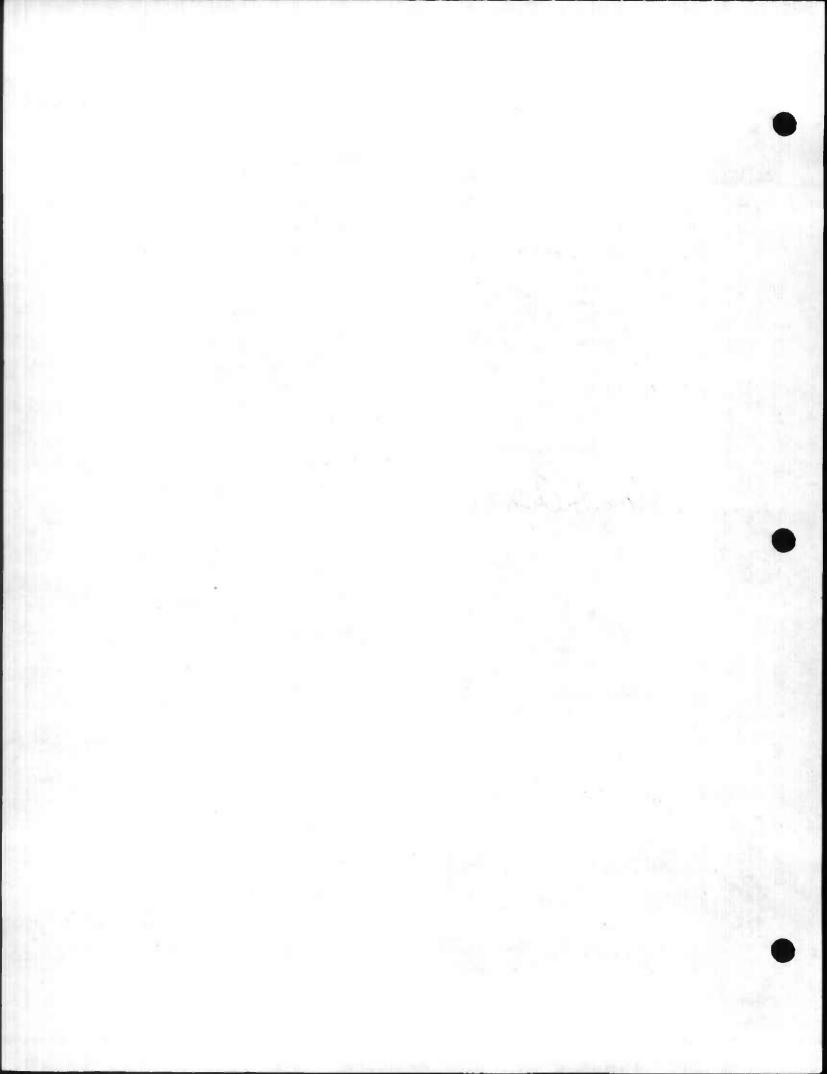


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

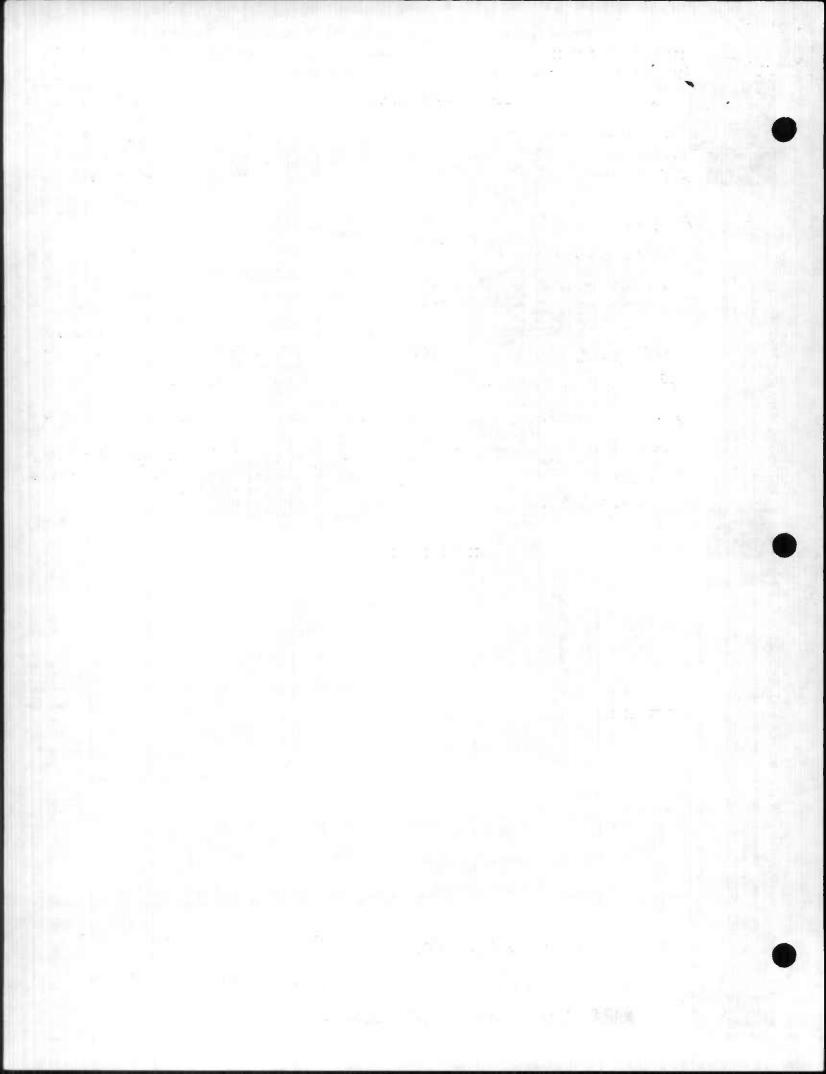
	1. Decedent's Nama (First, Middle, La.	st)	Ce	rtificate of	Deam	2. Data of Dec	Reg. No.		3. Time of Death
Physician	Evelyn P.	Ruby				Month March	3, 1999	Year	4:00 Ar
/Medical Examiner	4a Facility Nama (If not institution, give				4b. City, Town, or	Location of Death		of Death	
	3838 Roland Ave	enue Apartr	nent 14	04	Baltimo	re	N/A	1	
uneral rector	5. Social Security Number 6. S 220-07-3198	ex 7. Age (In) □ M 2000 87	vrs. last birthday) Yrs.	Months Day			, 1911	9. Birthpla Countr Maryl	ce (State or Forei y) and
ried at	10a. Stata 10b. County Maryland N/A	100	City, Town or Lo Baltimo				No.	10	d. Inside City Limit
terra 23a or 28a-f ahow ner ment be nothed at funeral Director	10e. Street and Number 3838 Roland Avenue	e Apt. 1404		10f. Zip Code 21	211 v		10g. Citizen of V USA	What Countr	y?
by F	11. Marital Status 1 Never Married 2 Married 3XXWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yas 2 No if Yes, Giva Year or Dates:		Was Decedent of If Yas, specify Cu 1 ☐ Yas = 2/☐(No	Hispanic Origin? (: ban, Mexican, Pua) Specify:	Specify Yas or No- rto Rican, atc.)		e - America ck, Whita, et : Whit	ic.
r, the Medical is Completed	15. Decedent's Ed (Specify only highest gra Elementery/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give		upation e during most of wo ed)	orking	16b. Kind of Br		
	17. Father's Nama (First, Middle, Last)		ПО	memaker	18. Mother's Na	ma (First, Middle,	Own Maiden Suman	Home	
To Be	Andrew W. Jones					h Jane	Sterner		
traum	19e. Intormant's Name/Relationship (1 Arthur T. Ruby, Ji				er Road,				
any injury or other	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Othar (Specify	Removal from Stata		osition (Name of matory or other pl		Data 3/6	20c. Location -	1	m, Stete Mary land
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should be detached for use as the burlet-transit letted by Physician/Medical Examir	Part II. Other significant conditions on	d	o (or as a consecutive of the consecutions of		iven in Part I.	23b. Did t			the cause of deat
N Q	THE PARTY OF THE P					24a. Was perfo	an autopsy med?	avai	e autopsy tinding lable prior to pletion of cause eath?
C Page	25. Was casa refarred to medical					101		10	Yas 2□ No
certificate has blirector, page 2 s	axaminar?	Hospital:	2 ☐ ER/Outpatie	2000	ther	eth (Check only o		as (Canalki)	
After this o funeral din ion: To	27. Manner of Death 1.☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Tima o	28c. Inj		28d. Describe i			
To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident invastigation 3 Suicide 6 Could not be 4 Homicide determined		I home, larm, sli ecify)			281. Location (S City or Tox		per or Rural	Route Number,
completely filled Medical Ce	29e. Certifier (Check only one)	rsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	n occurred et the vastigation, in my	time, date and plac opinion, daath occ	e, and due to the curred et the time,	cause(s) end modate and place,	enner as sta and due to t	ited. the cause(s)
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DHMH 16 Rev 6/95



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STERL	NG	1	1. Decedent's Name (First, Middle, La	st)				le UI	Dealli		2. Date of D	Reg. No.		3. Tima of	Death
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	/Medica Examine		4a Fecility Name (If not institution, giv GOOD SAMARITAN F						4b. City, Tov BALT		cation of Dea	fh 4c. County			
	Funeral Director		218 80 - 56	ex M 2□ F	7. Age (In yrs	. last birthday) Yrs.	If Und Months	er 1 Year Days		24 Hrs. Min.	8. Data of B (Month, D SEPT	irth ay, Year) 20,196/		place (State ontry)	
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		ř	19e. Informent's Name/Relationship (DURIS STEPLI	Type, Print)		19b. Mailin 542.	_	ss (Stree	44			ber, City or Town,			715
\$ 100 miles	- 1 5 6		20e. Method of Disposition 4 Surlal 2 Cremation 3 4 Donation 5 Other (Specific		State	Place of Dispo cematary, crar	esition (Natory or	other pla	ace)	00	Date 3-/07	20c. Location	- City or T	own, State	21
0	permit. Pages Department of important: If I any Injury or once.		21. Signature of Funeral Service Licer		- QNI	, 23	Name :	and Addr	EISTEI	LETUC	VN RO	m -/70%			Yom
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	Physician /Medical Examiner		Immediate Cause (Final disease or condition		SEIZURE	DISORDE	R							Onset and t	Jean
		Jei	resulting in deeth)	a	Due to	or es e consec	uenca o	·):					1		
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or as a consec	ju <i>e</i> nce of):					1		
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	of the d	/ Physic	Part II. Other significant conditions of FATTY LIVER	ontributing to de	ath but not re	sulting in the u	nderlying	cause g	iv <i>e</i> n In Part I.			tobacco use co			
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0	stelan: The lew certificate hes b director, page 2 s	Completed									1,100	Yes 2□No		Yes 2□	
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*	Physic ral dir	0	X☐ Yes 2☐ No 27. Menner of Death			ER/Outpatier		JUA		7		sidence 6 Math		ity) SCEN	E
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			30. Name and address of person who Strohen S. C.	completed caus		m 23a) (Type,	Print)	Str	reet, E	Balt	imore,	Marylan	d 212	201	
	State Registra	_	31. Date filed (Month, Day, Year) MAR 9 100	- 4	gistrar's Sign	ature	la	21	,						

DHMH 16 Rev 6/95



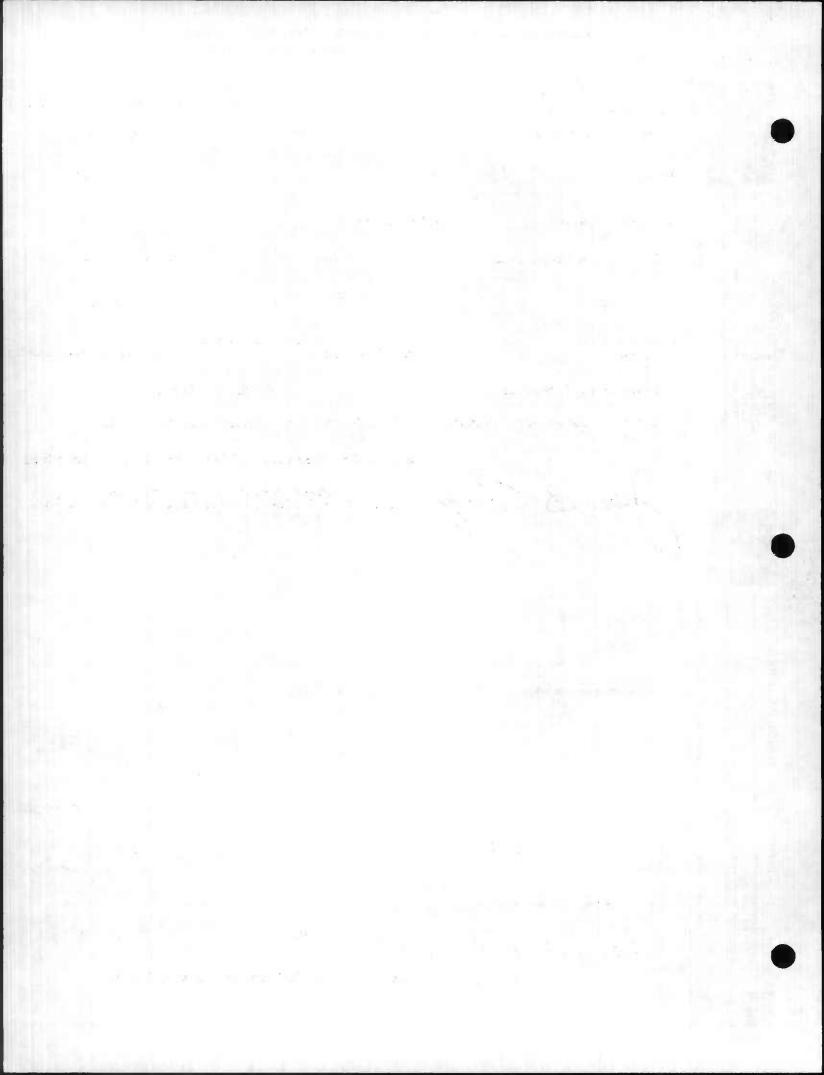
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State of Maryland / Department of Health and Mental Hygiene	Q	0	
Certificate of Death	3	2	

	1, [Decedent's Name	(First, Middle, I	Last)		17				2. Date of Dea		V	3. Time of Death	
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dical niner	40	Fecility Neme (If		ive street and n					own, or Lo	cation of Death		of Deeth		
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or	2	18-02-67	32	1 ☑ M 2 □ F		30 Yrs.	Months Days	Hours	Min.	Oct. 1	0, 1968		yland	
		ual Residence of	Decedent 10b. County		100 (City Town or Le	nantion							
-					1	City, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
ecto	Ma	aryland B. Street and Num	Carro	11		Union B	10f. Zip Code				10g. Citizen of V	Albet Coun		_
Funeral Director	100							1						
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by run		1 ☑ Never Marrie		Armed F	Forces? 2 ☑ No Sive		Was Decedent of I If Yes, specify Cub 1☐ Yes 2☑ No			Rican, etc.)		k, White, White,	etc.	
8	-		15. Decedent's	Education		16a. Dece	dent's Usual Occu	pation			16b. Kind of Bu			
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ge		Fether's Neme (i	First, Middle, La	st)	144			18. Mothe	er's Name	(First, Middle,	Maiden Sumam	ne)		
10		Franci	s P. Su	ter, Sr.					Mart	ha M. (Cugle			
	198	a. Informant's Na				19b. Maili	ng Address (Stree	t and Numb				State, Zip	Code)	
	I	Francis	P. Sute	r, Sr.	Father		McHenry	Road	Pik			2120		
	208	a. Method of Disposition 1 Statement 2 C		Removal from		Plece of Dispo cemetery, crea	osition (Neme of metory or other ple	ece)		Date	20c. Location -	City or To	wn, State	
		4 Donation			S	t. Char	les Ch.	Cemete	ery 3	/9/99	Pikesv	ille	Maryland	
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State Registrar

31. Date filed (Month, Day, Year) MAR 8



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month Harold Hayes Smith February 26,1999 3:30 am 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2442 Lakewood Road Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 11/28/1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours Min 1 M 2 □ F 235-20-0778 78 W. Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2442 Lakewood Road 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Datas: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Steelworker Bethlehelm Steel 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Columbus Smith Ada V. Stalnaker 19a. Informant's Neme/Raletionship (Type, Print) 19b. Mailing Address (Streat end Number or Rurel Routa Number, City or Town, Stata, Zip Code) Timothy Smith/Son 2442 Lakewood Rd. Parkville, Maryland 21234 20b. Place of Disposition (Nama of cemetery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Baltimore 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Cemetery Maryland 21. Signature of Funerel Service License 22. Name and Address of Facility David J. Weber Funeral Homes, P.A. 23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Bladder Cancer fmmediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2N No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homicide Certifying Physician: To the best of my knowledge, daath occurred at the time, date end place, and due to the ceuse(s) and manner as stated. | Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

that the death certificate be executed Box 68760. PO Division of Vital Records. or Attending Physician: 24 hours after death.

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show

"natural", or items 23s or

I Hygiene.

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: if item 27 is marked other that any injury or other traumatic event, that page.

Physician

/Medical

Examiner

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Physician/Medicai

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Medical Certification: To

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Funeral

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altimore. Maryland 21215-0020

Hospital

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> State Registrar

MAR 8

32. Registrar's Signature

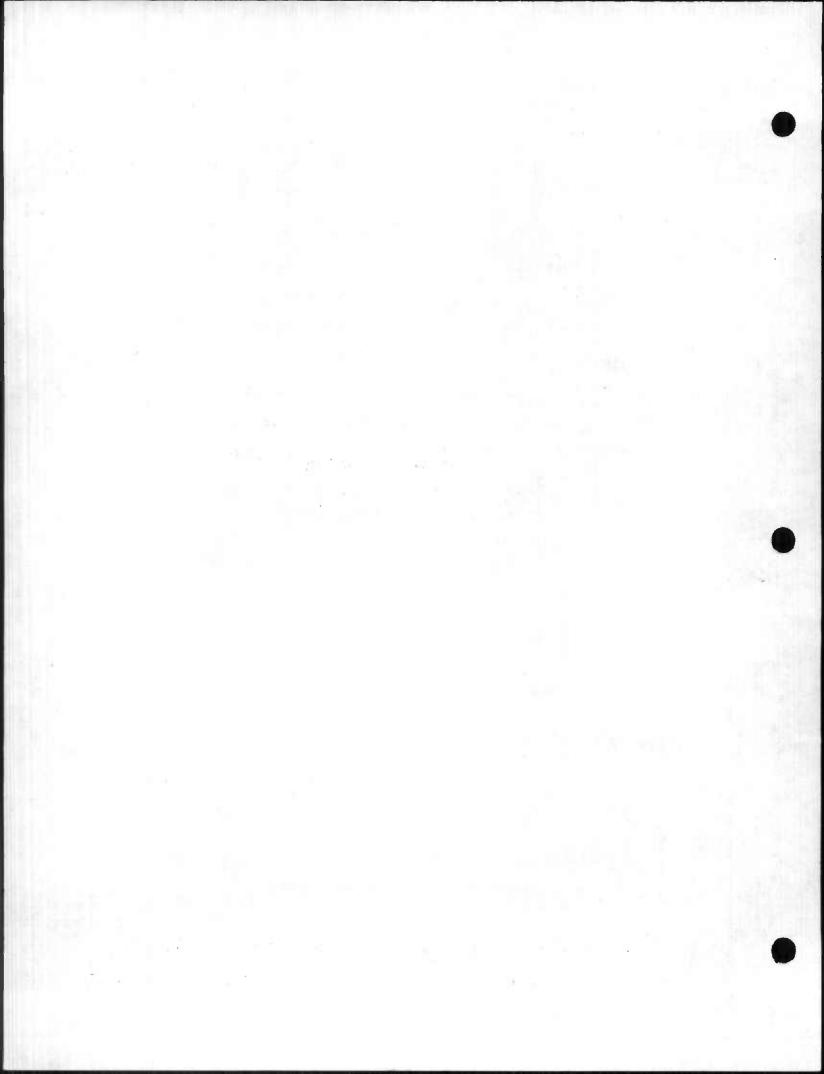
A Celexanderso

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
CARLAS. ALEXANDER, MD 29 S. GreeneSt., Ballmore, Md 21201

29b. Signature and title of certifier



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** Dorothy Sutch 1:00 am. /Medical 4e Fscility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Cherrywood Health Care Center Reisterstown Baltimore 8. Date of Birth Month, Day Year)
June 22, 1907 If Under 24 Hrs 5. Sociel Security Number If Under 1 Yeer 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 21 F Davs Maryland Months Hours 214-22-7427 91 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Baltimore Maryland Garrison Directo 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? the Medical Examiner must be n 8 Harden Ave. 21055 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rsce - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: by 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) Coitege (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: if Nem 27 is marked other tha any Injury or other two Cashier Food Market 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 88 William Hemling Daisy Alee Rote 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jane Allen 8 Harden Ave. Garrison, Md. 21055 20b. Piece of Disposition (Name of cometery, crematory or other place)
Metro Crematory 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete Baltimore, Md. March 9, 1999 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name end Address of Fecility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Deeth **Physician** Obstructus Pulyonas de sear Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Examiner elymona that the death certificate be executed burial-transi Sequentietly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or as e consequence of) physician a s the burial Box 68760. Physician/Medical Due to (or es e consequence of) attending USB Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 100 signed by Depres Sum 1 Yes 2 No 3 Probably 4 Unknown py 24b. Were autopsy findings sysilable prior to completion of cause of desth? Completed 24a. Wes en eutopsy performed? U890 has 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes cese referred to medicet examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury et Work? After 1 Naturet or Attending 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) MD 14286 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 3 AUTS MIGUEL SADOVNIK TREE LS. 1838 GREEN 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State MAR 8 1999 Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death Month March 3 Audrey 1210PM Toran 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Saint Agnes Baltimore Hospital If Under 1 Yeer | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Days Hours Min 1□M 2X F 79 Yrs. 214-18-5001 08 M.D. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnslde City Limits MYes 2□ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 711 North Woodington Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? U.S.A. 14. Race - American Indien, Black, White, etc. 21229 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: X□XWidowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th grade Housewife HOme 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Bertha Miller Edward Hollins 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Shirley Bailey-Daughter 915 Prestwood Road, Baltimore Md 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 3/8/99 Baltimore, Md 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility March F/H West 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. 21215 Approximate interval Between Onset end Deeth Immediete Cause (Final disease or condition resulting in death) 2 weeks Recipiratory Due to (or as e consequence of): phelimonia Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): sepsis Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown meningiona 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Was en autopsy parformed? hypertension Atrial fibrillation 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Waturel 2 Accident 5 Pending 1 □ Yes 2 □ No Investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 D Homicide 29a. Certifier taceritying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and menner es steted.

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: Hospital

attending physician and for use as the burial-transit been signed by the should be datached certificate has b director, Aftar this r death. • Funeral Direct letely filled in by To the Hosp within 24 hou To the Fune completely fi

Physician

/Medical

Examiner

Directo

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylen Department of Health end Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23s or 28s-f show any highry or other traumatic event, the Madical Exercises must be notified at once.

Physician

/Medical

Examiner

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Physician/Medicai

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Certification:

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(Check only one)

29b. Signature and the of cartifier

funeral

State Registrar 30. Neme and address of parson who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

2 Madical Examinar: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

29d. Dete signed (Month, Day, Year)

Miles 3,1999

salat Agnes James Heron 31. Date filed (Month, Dey, Yeer) MAR 8 1999

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A STATE OF THE STA 1900 again 1000 · mondoraphi Albanian Januari

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Michael J. Thomas 6, 1999 6:20am March 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Heritage Nursing Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 10 M 2□ F 214-09-7310 82 Yrs. 6-20-1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yas 2 No Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Paula Place 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Merchant Seaman Seafarers Int'l 4th 18. Mother's Name (First, Middla, Maiden Sumama) 17. Fether's Neme (First, Middle, Last) Michael J. Thomas Sr. Bertha Unknown 19e. Informent's Name/Relationship (Type, Print) Wife 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Paula Place, Baltimore, Maryland 21237 Sandra Thomas 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Greenmount Cemetery 3-9-99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Joseph N. Zannino Jr. Funeral Hm. 21. Signature of Funeral Sarvice Licenses annexo 263 S. Conkling St., Baltimore, Maryland 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of) Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one)

Physician /Medical Examiner

certificate be exec Box 68760

Division of Vital Records,

Injury or

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/Medical

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Director

Item 27 is marked other than "natural", or itema 23a or 28a-f show other trsumatic event, the Macical Evanthar must be notified at

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altimore, Maryland 21215-0020

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Examiner physician end s the buriel-trans Physiclan/Medicai 200 nse for 9 à 8 Completed page 2 funeral director, Be Certification: To

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certificate hes

• Hospital or Attending Physician: 24 hours efter death. • Funeral Director: After this certifica

To the Vithin 2

25. Wes case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

2☐ Medical Ex

28e. Date of Injury (Month, Day Year) 28b. Time of

28e. Placa of Injury - At home, farm, straet, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Tyes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated

(Check only one) 29b. Signature and title of

29a. Certifier

29c. License number

aminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name ay 4 ad pleted cause of death (Item 23a) (Type, Print) emun en

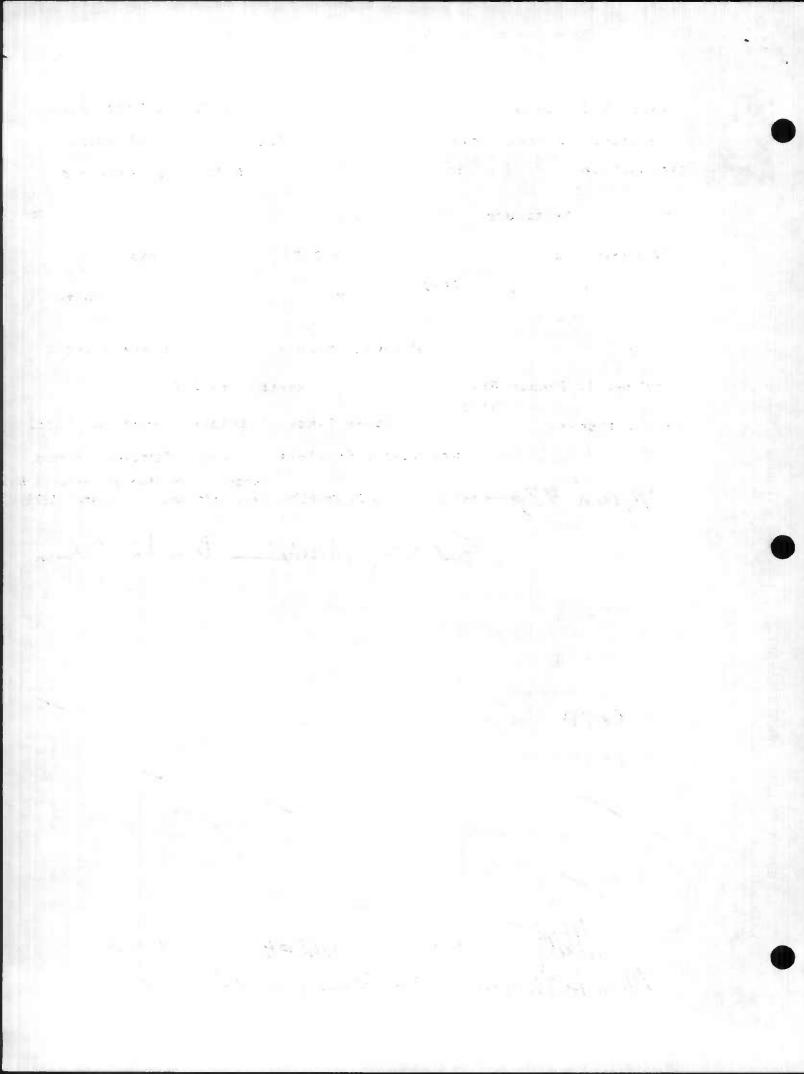
State Registrar

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Medical

31. Date filed (Month, Day, MAR 8

32 Registrar's Signature

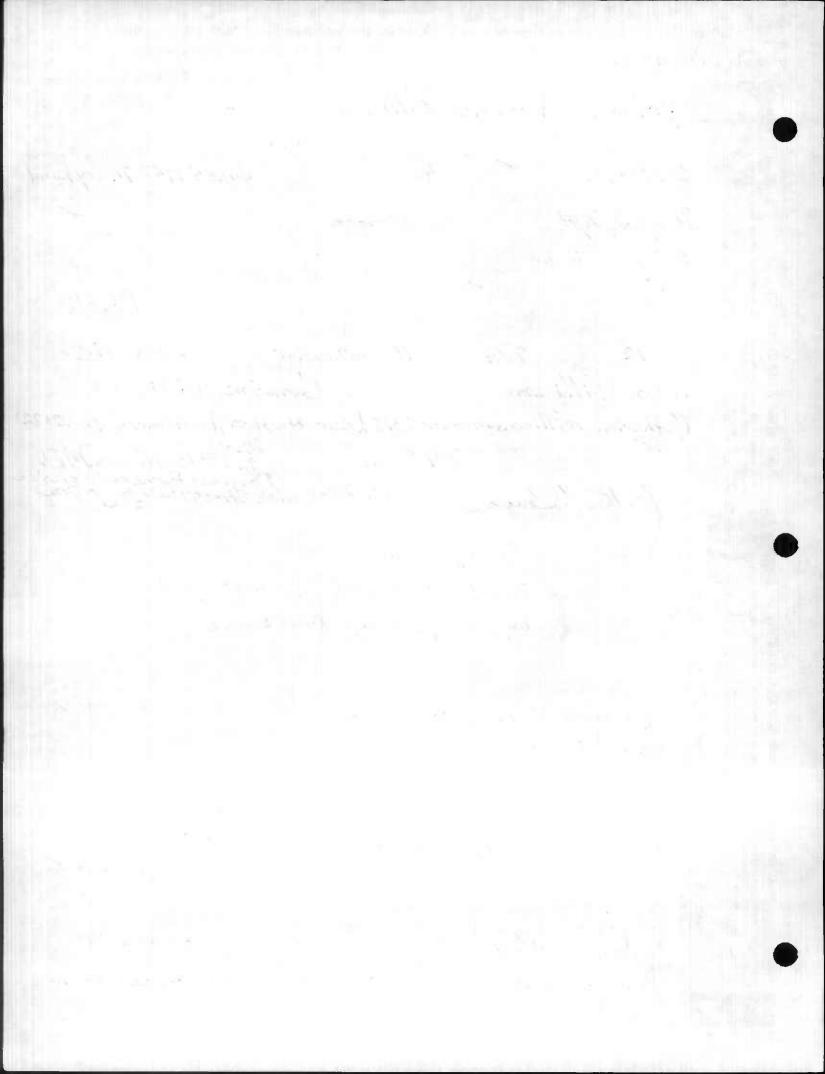


rn		onne Williams	State of Marylan	d / Department of I Certificate of		ental Hygiene 9	07153
	Physicia /Medica	yolanda	Vunne 1	Williams	4b. City, Town, or Loc	2. Data of Death Month Day March 04, 199	
	Funeral Director	2312 Lauretta Av 5. Social Security Number 6.		(ast birthday) If Under 1 Year Months Days	Baltimore If Under 24 Hrs. Hours Min.		
Baltimore, Maryland 21215-0020	e filed within 72 hours self Hygiene. I other than "natural", overt, the Medical Even	10a. State 10b. County Marchal 10e. Street and Number 10b. Street and Number 11. Marital Status 12 Nevar Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Elementary/Secondary (0-12) 17. Fathar's Name (First, Middle, Last 19a. Informant's Name/Relationship 29a. Method of Disposition 1 Paurial 2 Cramation 3 Canada Control of Secondary (2-1) 21. Signature of Funeral Sarvice Lice	12. Was Decedent Ever in U, Armed Forces? 1	If Yas, specify Cub 1 Yes 2 No 16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Home Ma	Hispanic Origin? (Specian, Mexican, Puerto F Specify: pation during most of workin during most of workin at and Number or Rural retta flv ice) M 9	g If the special spec	ce - Amarican Indian, lock, White, etc. Black Susiness/Industry Dest/10 ma)
x 68760,	ysician and	23a. Fart1. Enter tha disease or construct, or heart failure. List only Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Perforation of Due to (or c. Comple Caping	ras a consequence of): themodially ras a consequenca of):			Approximate Interval Between Onset and Death
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<u>N</u>	pital or At ours after o eral Direct filled in by	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, offica		8f. Location (Straet and Num City or Town, State)	a La wrete Ave
	• Hos 24 h • Fur	(Check only one) 2 Medical Example one)	miner: On the basis of examinat and manner stated.				
)	To the Hospital of within 24 hours at To the Funeral D completely filled in	29b. Signature and little of certifier	Muth		se number C.M.E.		ed (Month, Day, Year) 04, 1999
	State	21 Date filed (Month Day Veral	completed causa of death (Item Lute M) 32. Registrar's Signal	111 Per	n Street,	Baltimore, Ma	aryland 21201

State Registrar

1999 MAR 8

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

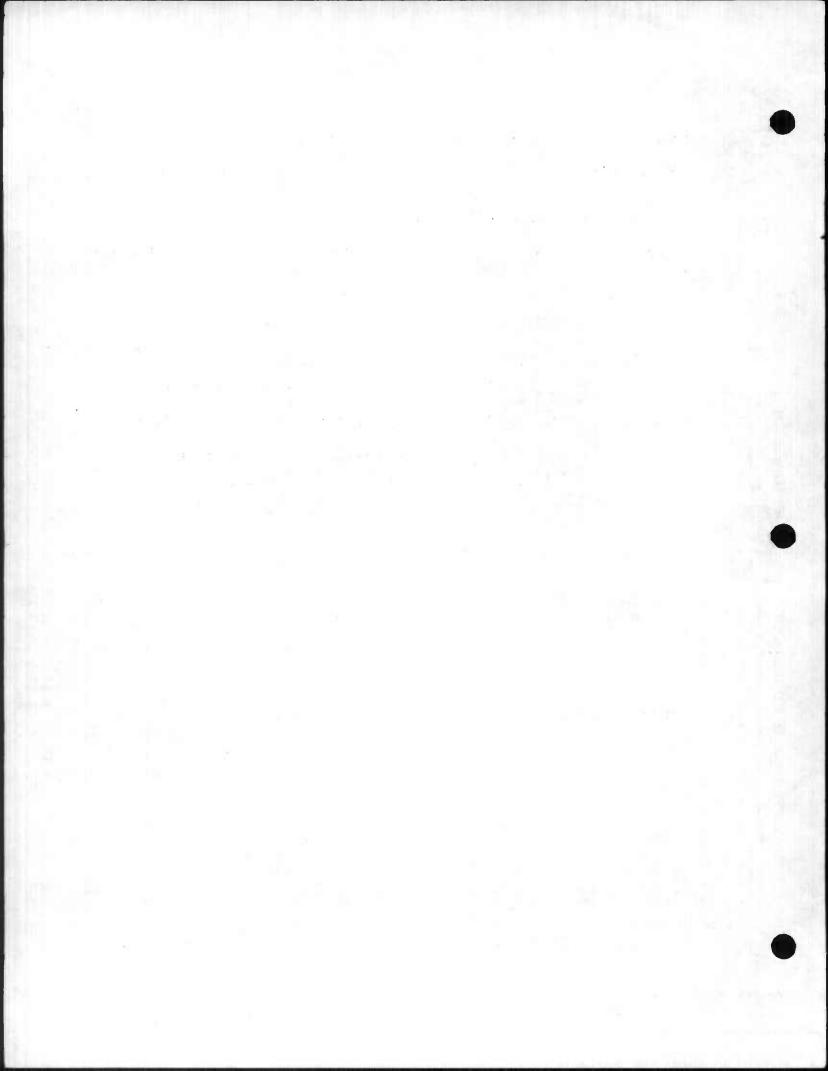
State of Maryland / Department of Health and Mental Hygiene 15 L

			Ce	ertificate o	f Death		Reg. N	No.	
	1. Decedent's Nama (First, Middle, Las	st)	74 - 3				of Death	- 990	3. Time of Death
Physician /Medical	Sarah Anne Warre	n				Marc	n 7	7 1999	7:00am.
Examiner	4a Facility Name (If not institution, give	e street and number)			4b. City, To	wn, or Location of	Death 4	Ic. County of Death	1
	502 Rocklyn Ave.				Pike	sville		Baltimor	e
Funeral Director	5. Social Security Number 6. S 219–38–5579	ex 7. Aga (In yrs 88	last birthday, Yrs.	If Under 1 Ye Months Day		Min. 8. Date	of Birth	9. Birth	oplace (State or Foreign intry) Ireland
2	Usuel Residence of Decedant								
the Marylar 28a-f show notified at	10a. Stete 10b. County Maryland Baltimo		ity, Town or L Pikesv						10d. Inside City Limits 1 ☐ Yas 2 ☐No
death with the Maryland rms 23s or 28s-f show rms to notified at neral Director	10e. Street and Number 502 Rocklyn Ave.			10f. Zip Cod 2120	-			Citizen of What Cou	untry?
or he miner	11. Meritel Stetus 1 Nevar Marriad 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No It Yes, Give Yeer or Detes:	J,S. 13.	Was Decedent of If Yes, specify C		gin? (Specify Yes , Puerto Rican, et	or No- c.)	14. Race - Ameri Black, White Specify: W	
5-0 72 hr	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Oc	cupation	of working	16b.	Kind of Business/li	ndustry
1 21215-0020 ed within 72 hours ef ygiene are than "natural", or nt, the Medical Exam Completed by F	Elementery/Secondery (0-12)	College (1-4or 5+)		kind of work do DO NOT use ret Housewif		Of WORKERY	H	Homemaker	
be filed tal Hygid of other event, Be Cc	17. Fether's Nema (First, Middle, Last)				18. Mothe	r's Name (First, N	liddle, Maide	en Sumame)	
ylan Wentat Ment	Lawrence Hester				El:	izabeth 1	Beirne		
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Baltimore, Maryland 21215-002 bemit, Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa and. To Be Completed by	20e. Mathod of Disposition 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify	Removal from State	Plece of Disponentery, cre	osition (Name of ematory or other p	olace)	Date 10, 1999	20c.	Location - City or T	Town, State
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Physician	snock, or neer tellure. List only	one cause on each line.							Intervel Between Onset end Death
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death certificate be executed eath certificate be executed of for use as the burial-transit sician/Medical Examiner	Sequentielly list conditions, if any, teading to immediate cause. Enter Underlying Ceuse (Disease or Injury	Due to (or es e conse	quence of):	Hans.				
68760, ficate be execu- physician and is the burial-tra- edical Exar	Ceuse (Diseese or Injury thet initieted events resulting in death) Last	C. Due to (or es a consec	quence of):					
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- Z 50 D	1 Yes 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	Other: 4 Nu	rsing Home 5 🖻	Residence	6 Other (Spec	city)
E 5 5 0	27. Mannerof Death 1 ☐ Naturel 5 ☐ Pending 2 ☐ Accident Investigation	28a. Dele of Injury (Month, Dey Yaer)	28b. Tima o tnjury	V	ijury at Vork? □ Yes 2 □ I		cribe how in	jury occurred	
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After templetely filled in by the funeri	2 Accident Investigation 3 Suicide 6 Could not be determined		nome, ferm, st			28f. Loca	tion (Street or Town, Sta	and Number or Ru ate)	ral Route Number,
To the Hospital or within 24 hours after To the Funeral Director Completely filled in Medical Cert	29a. Certifier 1 Certifying Phy (Check only one)	yalcian: To the best of my known iner: On the basis of axamine and menner steted.	owledge, deat etion and/or in	th occurred at the envestigation, in m	time, date and y opinion, deel	d place, and due t th occurred at the	o the cause time, date a	(s) and menner as and place, and dua	stated. to the cause(s)
Vithin To the comple	29b. Signature and title of party for	1 0		29c. Lice	ense number		29d. D	Data signed (Month	n, Day, Year)
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4a Facili	ty Name (If not	institution, give	street and nu	mber)			4b. C	City, Town, or	Location of Dea		
	olia Ce Security Number				care rs. last birthday)	If Under 1	Year H	anham Under 24 Hrs			e George's 9. Birthplace (State or Fo
	3-36-559	15	□M 2[X]F	97	Yrs.	Months	Days H	lours Min	Nov. 6	, 1901	Virginia
10a. Stat		. County		10c.	City, Town or Lo	cation					10d. Inside City Li
	1and P		George'	s La	nham	10f. Zip C	ada			10g. Citizen of \	1 Yes 2
11.0-10.0	0 Good		nad				706		10.5	United :	
11. Marit	al Status Never Married Widowed 4	2 Married	12. Was Dec Armed Fo 1 Yes If Yes, Gir	orces? 2 (XNo we			nt of Hispa y Cuban, M	nic Origin? (: Mexican, Puer pecify:	Specify Yes or Norto Rican, etc.)		ce - American Indian, ck, White, etc.
312	15.	Decedent's Edi			16a. Deced	dent's Usual	Occupation	n ng most of wo		16b. Kind of B	usiness/Industry
Eleme	(Specify or ntary/Secondary	nly highest grad y (0-12)	College (Cler	DO NOT use	done durin retired)	ng most of wo	orking	Library	y of Congress
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resulting	or condition in death)		b	Due to	Irome In	juence of):	- Ca				l week
mat mitte	ially list conditionading to immedienter Underlying Disease or injury ted events	ns, iate	С.		(or as a conseq						
resulting	in death) Last	L	d								
Part If. Of	her significant	conditions co	ntributing to de	eath but not r	esulting in the ur	nderlying cau	ıse given in	n Part I.	23b. Did	I tobacco usa co	ntribute to the cause of de
Ath	eroscle	erotic H	Heart D	isease					1	Yan 2 No	3 Probably 4 Unk
										s an autopsy ormed?	24b. Were autopsy findir available prior to completion of cause of death?
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exam	case referred to iner? res 2 💢 No	-	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3□ DOA	Other		eth (Check only	one) sidence 6 □Oth	nor (Consike)
27. Menn 1 🖾 N	er of Death	Pending investigation	28a. Date	-	28b. Time of		: Injury at Work?	2□No	1	how injury occur	
	Suicide 6 (Homicide	Could not be determined	28e. Place buildi	of Injury - Aling, etc. (Spe	home, farm, stri cify)	set, factory, o	office	Yà		(Street and Numb own, State)	ber or Rurel Route Number,
401		Cartifician Physics	sician: To the	esis of exami	nowledge, death nation and/or inv	occurred at restigation, in	the time, d	iate end plac on, death occ	e, end due to the urred at the time	cause(s) and me , date and place,	enner as stated. and due to the cause(s)
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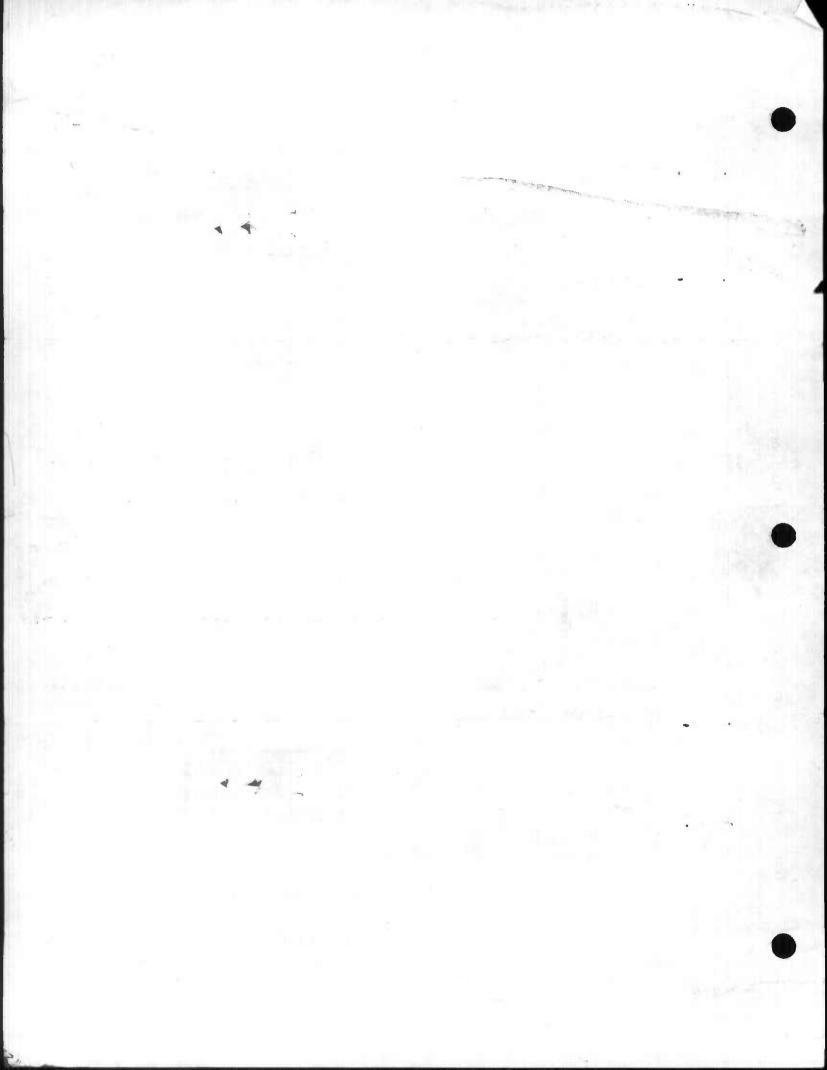
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Any CATHERINE AUSTIN /Medicat 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel 8. Dete of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplaca (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 10 M 20 F Months 88 Yrs. 5,78-24-9947 Aug. 1910 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Mental Hygiens.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show with injury or other treumatic event, the Medical Examples must be incurred an entited. 10d. Inside City Limits 1 Yas 2 No Prince George's Director Md. Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5508 Helmont Drive 20745 United States Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Minister of Music Musician 12th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Unknown Elizabeth Taylor 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) Alphonse Certain / Friend 5508 Helmont Drive Oxon Hill, Md. 20745 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) Lincoln Memorial Cem. 2-8-99 Suitland, Md. 22. Name and Address of Fecility Capitol Mortuary 21. Signature of Funeral Service Loens 1425 Maryland Ave., NE Wash., DC 20002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tellure. List prily one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) 1000 /Medical 5EP515 Examiner Due to (or as e consequence of): Examine PNEUMONIA LOOK ettending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or Injury Due to (or es a consequence of): Years BRAIN SYNMOME 68760 02612211C Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of): Box P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 à 1 Yes 2 Ho 3 Probably 4 Unknown 05080 my 821715 of VItai Records. P 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed hes 1□ Yes 2□No 1 Yes 2 No After this certificate Be 25. Wes case reterred to medical 26. Flace of Deam (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 2 28a. Date of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours effer death. To the Funeral Director: After th complately filled in by the funera edical Certification: Division 5 Pending investigation Neturel Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and menner steted. 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture and titla of certifier 1725422 JANUARY 31, 1999 BALTMORE 1784 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13952 ROBENT 20707 W1998(N, MD LAURA, MARYLAND 31. Dete tiled (Month, Day, Year) 32. Registrar's Signetura State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician ESTA** FEBRUARY BUTTS 1999 5:30 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WILLIAMSPORT NURSING HOME WILLIAMSPORT WASHINGTON If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
JULY 2, 190 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F Deys Yrs. Director 92 1906 216-22-7636 MARYLAND Usual Residence of Deceden 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Director MARYLAND WASHINGTON WILLIAMSPORT 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 NORTH ARTIZAN STREET 21795 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: g Specify 3 ₩idowed 4 Divorcad WHITE Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANDREW GRANT REEDER 2 LAURA VIRGINIA POFFENBERGER 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar important: If Item 27 is eny injury or other trau soc. C. LEE BUTTS JR./SON 119 EAST POTOMAC STREET, WILLIAMSPORT, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) BOONSBORO CEMETERY 2/25/99 BOONSBORO, MARYLAND 21. Signature of Puneral Service LiCansee 22. Name end Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Ma Boonsboro, Maryland 21713 al 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediete Cause (Final PNEUMONIA 3 DAYS disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 450 Unknown CACHEXIA DEHYDRATION þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? 1 ☐ Yes 2/2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Injury 1 Yes 2 No 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 00 D33700 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ted E Howe M. C 31. Date filed (Month, Day, Year) FEB 2 3 1999 Overlook Dr. Boonsboro, MD 21713 32. Registrat's Signature 15421

State Registrar

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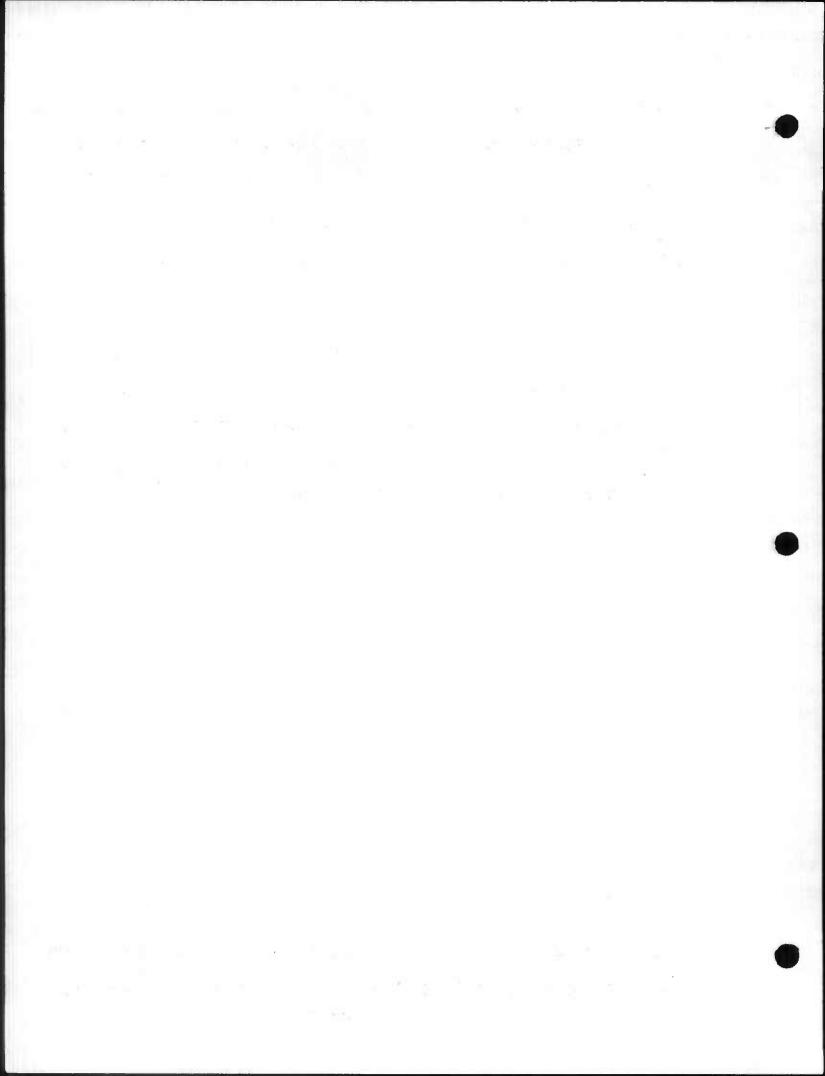
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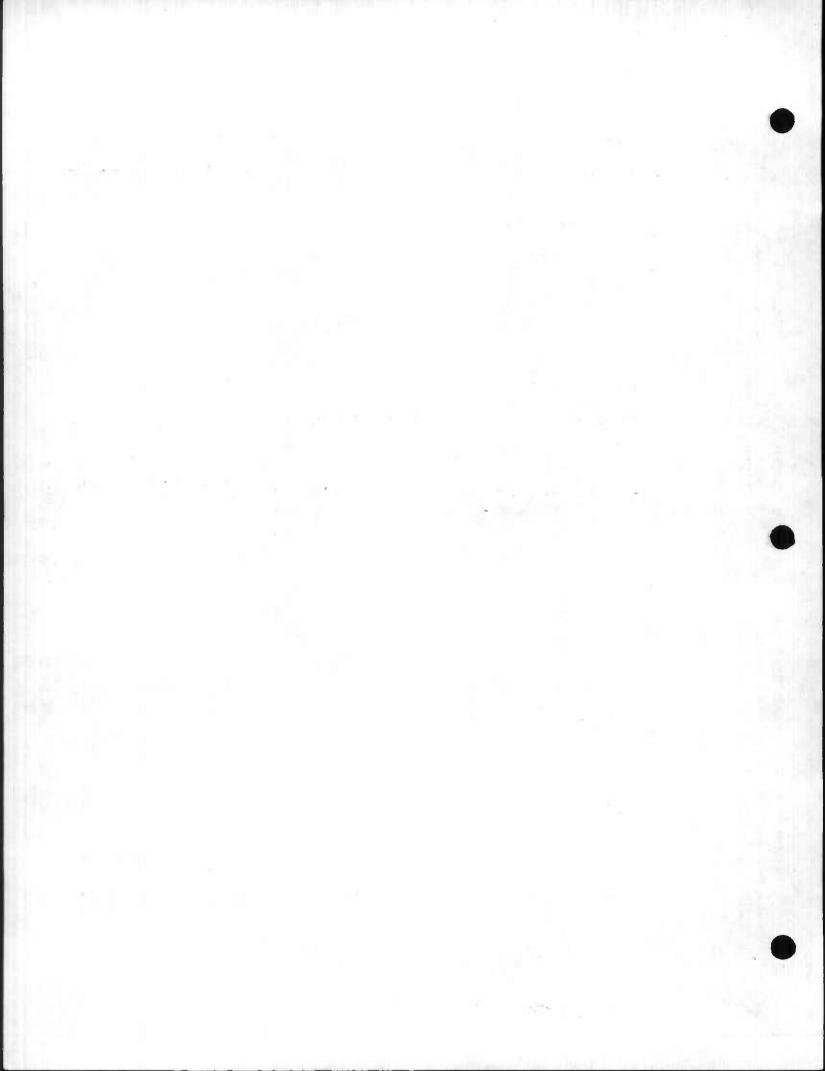
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Baltimore, Maryland 21215-0020



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MARYLAND WASHINGTON BOONSBORO 1870 100, 200 Colises of What Country? U.S. A. 1.5 West Decedent Ever in U.S. 1.5 West		Usuel Residence of Decedent		7, 7,70
Tot. Street and Number Tot. Street Tot. Zep Code Tot.		10a. Stele 10b. County 10c. City, To	wn or Location	10d. Inside City Limits
141 South Main Street 21713 U.S.A.	cto	MARYLAND WASHINGTON	BOONSBORO	1 N Yes 2 No
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29b. Signature and title of certifier / , 29c. License number 29d. Date signed (Month Day Year)	Wed Wed	and marrial stated.	20e Lisanos numbos	Ond Date signed (Month Day York)
29c. License number 29d. Dete signed (Month, Dey, Year)	8 -	DU A		254. Dete signed (month, bey, real)
Mulu D32518 2.21.99		Mulux	0323 18	2.21.79
30. Name end address of person who completed cause of cleath (Item 23a) (Type, Print)		30. Neme end address of person who completed cause of death (Item 23a	(Type, Print)	,
Dr. Duebliset 100 Setting The Kedysville, Md.		Dr. sudnet 100 felling	+ The bladyoull	e, md.
State 31. Defe filed (Month, Day, Year) FFB 2 2 1999 Sports		31. Dele filed (Month, Day, Year) 32. Registrar's Signature	D. Somethy	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 17, 1999 **Physician** Mattie Ruth Blacklin 4:00 P.M. /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14807 Daley Rd. Hagerstown Washington Hage Lacov...

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
1621. 15, 1908 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) Virginia Funerai 1□M 20 F Months Deys 218-34-4853 90 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiena. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Funeral Director Washington 1 ☐ Yes 2 ☐ No Md. Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14807 Daley Rd. 21740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Ironer, Mangle worker Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Charles E. Montgomery Elizabeth Oates 2 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Blacklin (Son) 14807 Daley Rd. Hagerstown, Md. 21740 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2 Cremation 4 Donat 5 Other (Specify) Smithsburg Crematory Feb. 18,1999 Smithsburg. Md. 22. Name end Address of Fecility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediete Cause (Final disease or condition resulting in death) Allegical MITRAL VALVULAR DISEASE 20 YRS Examiner Examine or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest and Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? been signed by should be detact 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Aftar 5 Pending Investigation 1 Naturel within 24 hours after death.

To the Funeral Director: All complately filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical (Check only one) To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

BARRERA, IR

500 MEMOZIAL AVE

CUMBERLAND, MP 24502

State Registrar

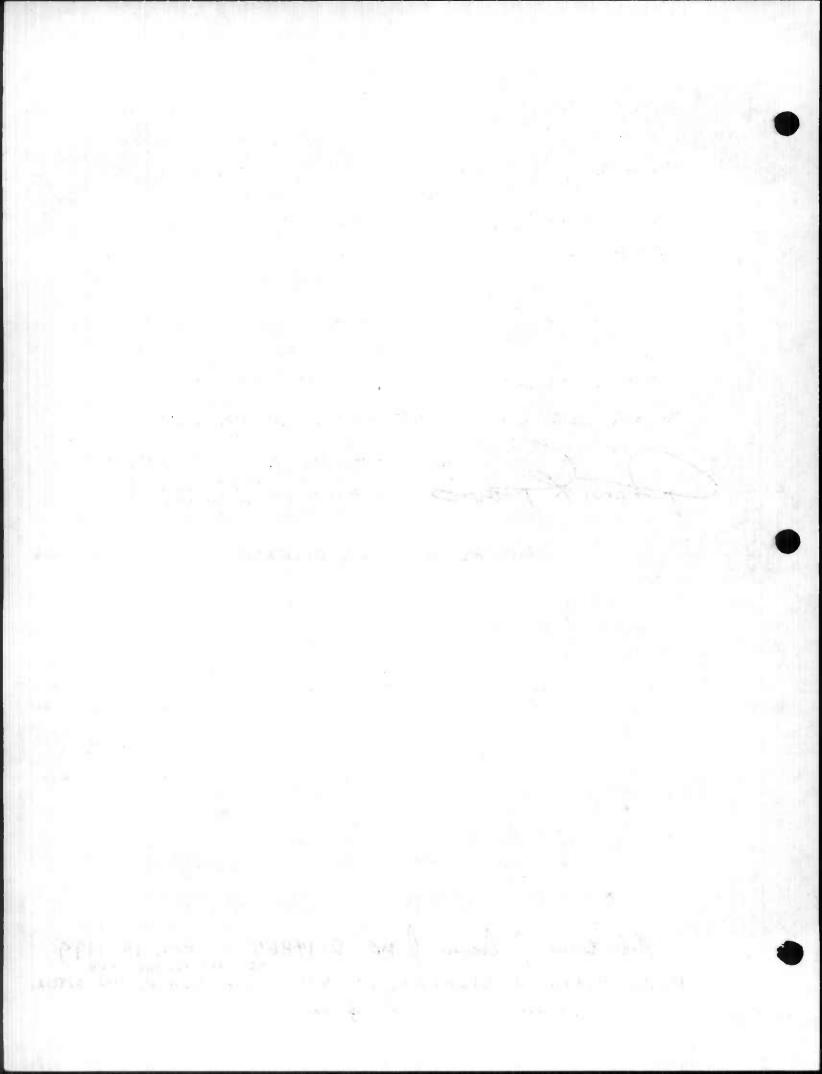
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

FEB 2 4 1999

KOBUSTIANO 31. Dete filed (Month, Day, Year)

1,

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. ITEM: #12 PER F.H G769 3-24-99 WR. Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death LAWRENCE J. BLOCH FEBRUARY 15, 1999 1:25 I.M. 4e. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 5 Social Security Number If Undar 1 Yeer If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Deta of Birth (Month, Day, Year) Days Hours 1 XM 2 ☐ F 086-03-7868 Yrs. 78 SEPT. 30, 1920 NEW YORK Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY CHEVY CHASE 1 ☐ Yas 2 XNo 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 4620 NORTH PARK AVENUE 20815 U.S.A. 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 No WHITE Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) ACCOUNTANT U.S. GOVERNMENT 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Sumama) OTTO BLOCH CHARLOTTE SCHROTTMAN 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1050 CONNECTICUT AVENUE, NW, WASHINGTON, DC 20036 SUITE 825 19a. Informent's Name/Ralationship (Type, Print) ATTORNEY JAY FREEDMAN 20a. Mathod of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata BALTIMORE/WASHINGTON CREMATORY 1 ☐ Burial 2 Cremetion 3 ☐ Ramoval from Steta 2/24/99 LAUREL, MARYLAND 4 ☐ Donetion 5 ☐ Othar (Spacify) 21. Signature of Funarat Service Licenses JOSEPH GAWLER'S SONS, INC. 5130 WISCONSIN AVENUE NW, WASHINGTON, D.C. 20016 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or part failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediate Causa (Finet disease or condition resulting in death) eymonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Lest Due to (or es e consequance of): Due to (or as a consaquence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文 Unknown 24b. Wara eutopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 200 No 1 Yas 1 ☐ Yes 2 ☑ No 26. Plece of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28b. Time of 28d. Describe how tnjury occurred

end the buriel-trei signed by I Attanding Physician:

P.O.

Division of Vital Records,

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24 hours

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Physician

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filed within 72 hours after

Hygiene.

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permit. Page Depertment of Important: If any Injury or once.

Physician /Medical

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other traumstic event,

21215-0020

Baltimore, Maryland

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3/6/99

SLOCH, LAWRENCE

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3 Sulcida

29a, Certifier

4 T Homictde

25. Wes casa rafarred to medical 27. Menner of Death 1 Natural 2 Accident

5 Panding Invastigation

6 Coutd not ba

28a. Date of Injury (Month, Dey Year) 28a. Ptece of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

MO

28c. Injury et Work? 1 Yas

2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

15 Certifying Physicien: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar

29c. Licansa numbar

29d. Date signed (Month, Day, Year)

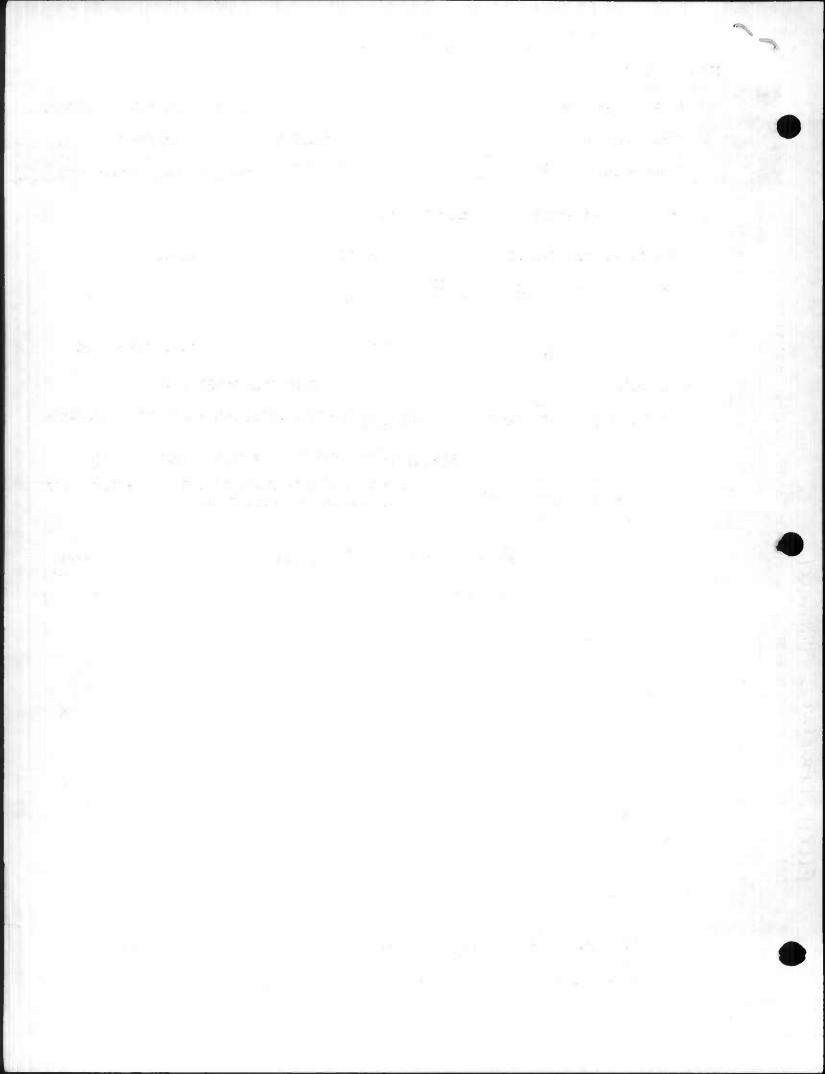
30. Name end eddrass of person who completed causa of death (Item 23a) (Type, Print)

18111 PrPhilip Dr Suite 212 Olney MD 20832 MENDHIRATTA 31. Data filed (Month, Day, Yaar)

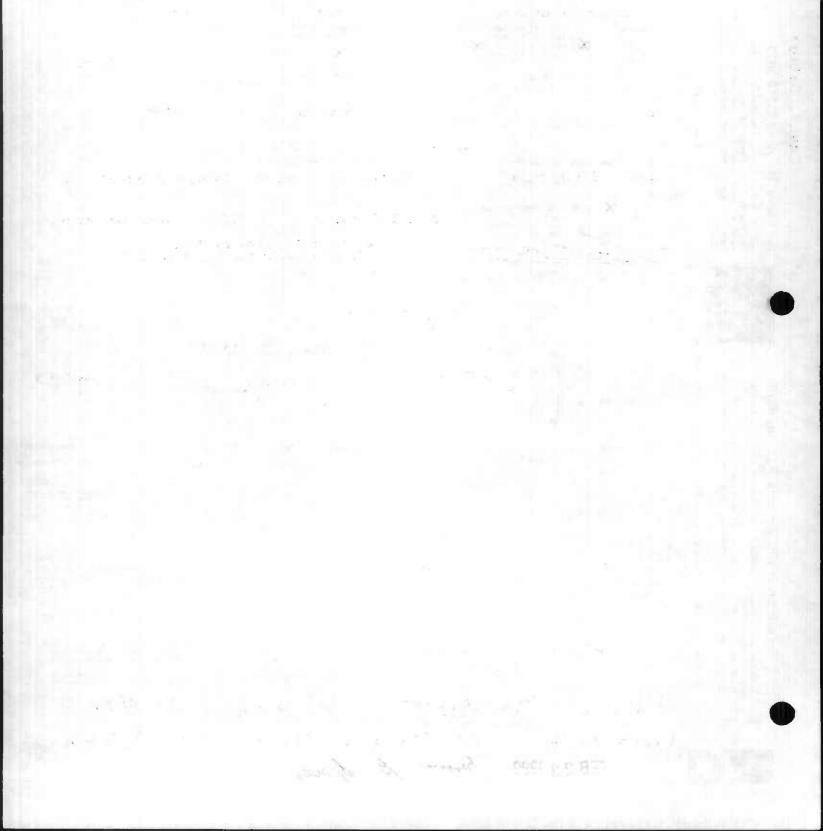
State Registrar

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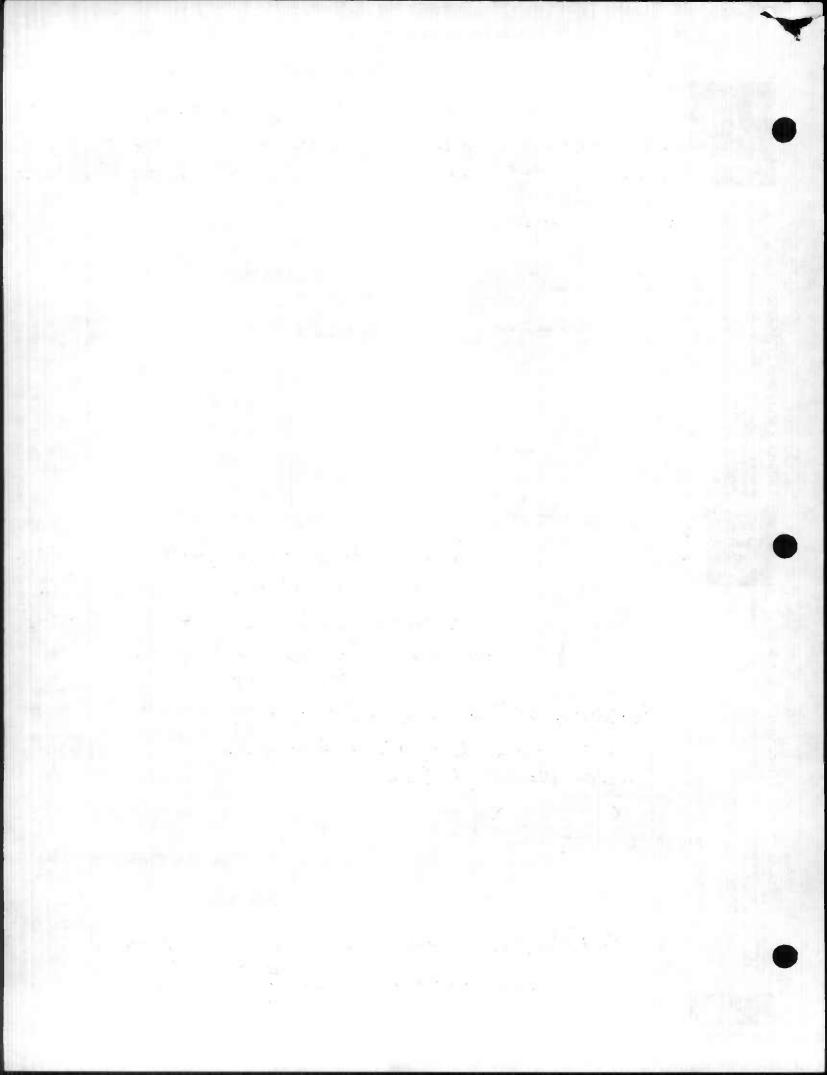


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		Method of Disp Burial 2	Cremation		noval from S	State	Place of Disp cemetery, cre apito1	osition (Ne metory or	ome of other plea	ca)	Date 2/22/99	20c. Loca	ation - City or	Town, State
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. 62 State of Maryland / Department of Health and Mental Hygiene Amend #7, 2/22/99, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Martha Baker 18, 1999 Feb. 3:00 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner Prince George's General Hospital Cheverly Prince George's 7. Age (In yrs. last birthday) If Under 1 Year 79 yrs. Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) **Funeral** 1□M 21 F Director Sept. 27, 1919 227-02-6241 Garrett, KY Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director VA Tazewell N. Tazewell 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be o Route 7 Box 90 24630 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0020 'natural', or 1 Yes XXNo Specify: by 3 Widowed 4 □ Divorced Completed 18a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Unknown Own Home marked offser 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be and Mental John Morgan Whitt Nancy Jane Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) opatiment of Health an Important: if them 27 is n any injury or other 2005 Route 2 Bluefield, VA 24605 Joe Baker - Son 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Grandview Memory Gardens 2/22/99 4 ☐ Donetion 5 ☐ Other (Specify) Bluefield, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dudley Memorial Mortuary Part I finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock or heart fellure. List only one cause on each line. 24605 Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificete be executed physician end s the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 No 3 Probably by 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was an autopsy performed? Completed peed page 2 s Knal 1 Yes 2 No alule certificate 25. Was cese referred to medical examiner? or Attending Physician: director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 After the funeral 27. Manger of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident Investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Discompletaly filled in 29a. Certifier Kucrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. within 2. To the I 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number 24720 ed cause of death (Item 23a) (Type, Print) AVINOGR over Ma 32. Régistrar's Signature State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Day Month Year **Physician** WILLIAM 20, 3:45 PM J. BARTOS FEB. 1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TAKOMA PARK MONTGOMERY WASHINGTON HOSPITAL ADVENTIST if Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 6. Sax Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days 1⊠M 2□ F Hours 85 Director 160-03-3969 2, PA. Usual Rasidance of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow XX Yes 2 No Director MD. PRINCE GEORGES HYATTSVILLE 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò Itama 23a 7611 24th AVE. 20783 Funeral U.S.A. death 12. Was Decedant Evar in U,S. Armed Forcas? 1 DYes 2 No 1 Yes, Giva Yaar or Datas: WWII Was Decedant of Hispanic Origin? (Specify Yas or Nott Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after on of Health end Mentel Hygiene. Ont of Health end Mentel Hygiene. Of: If Itam 27 Ia marked other than "natural", or itae 1 ☐ Nevar Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITTUE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) Collega (1-4or 5+) SUPERVISOR FURNITURE WAREHOUSE 18 Mothar's Name (First Middle Maiden Sumama) 17. Fathar'a Nama (First, Middla, Last) Be CASPER BARTOS PAULINE ZEMBA 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 Depertment of Health e Important: If Itam 27 Ia any Injury or other trai PAULINE M. BARTOS/WIFE SAME AS ITEM #10 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 □ Burlal 2 ☑ Cramation 3 □ Ramoval from Stata 4 Donation 5 Othar (Specify) CHAMBERS CREMATORY 2/23/99 RIVERDALE, MD. 21. Signature of Funaral Sarvice Licenses 22. Name and Addrass of Facility MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in deeth) /Medical Nelmer Examiner Due to (or as a consequance of): Examiner Leu monia ician and burial-transit the deeth certificate be executed Sequentially list conditions, if any, leeding to immadiata causa. Enter Undarlying Cause (Disaase or injury that initiated evants rasulting in death) Last Due to (or as a consequence of) physician s the burial levotic Box 68760. MRIBSE Physician/Medical Dua to (or as a consequance of) 950 ed by the a 23b. Dtd tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown The lew requires that signed t Division of Vitai Records. þ 24b. Wara autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 2 No 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa ratarred to medical axaminar? Be 26. Place of Death (Check only ona) To Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Minpatiant 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Mennar of Deeth 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? edical Certification: or Attending 1 DiNetural 2 Accidant 5 Pending invastigation 1 TYes 2 □ No 24 hours after deeth.

Funeral Diractor: A 6 Could not be determined 28a. Plece of Injury - At homa, tarm, street, tactory, office building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifian 29c. Licansa number 29d. Data signad (Month, Day, Year) 7. 6 30. Name and address of person who complated causa of dagth (Itam 23a) (Type, Print) 0 2 HITH Q. Ho 71 31. Data tiled (Month, Day, Year) 出 Marylan 7610 arroll Ave 280

State Registrar 32. Registrar's Signatura

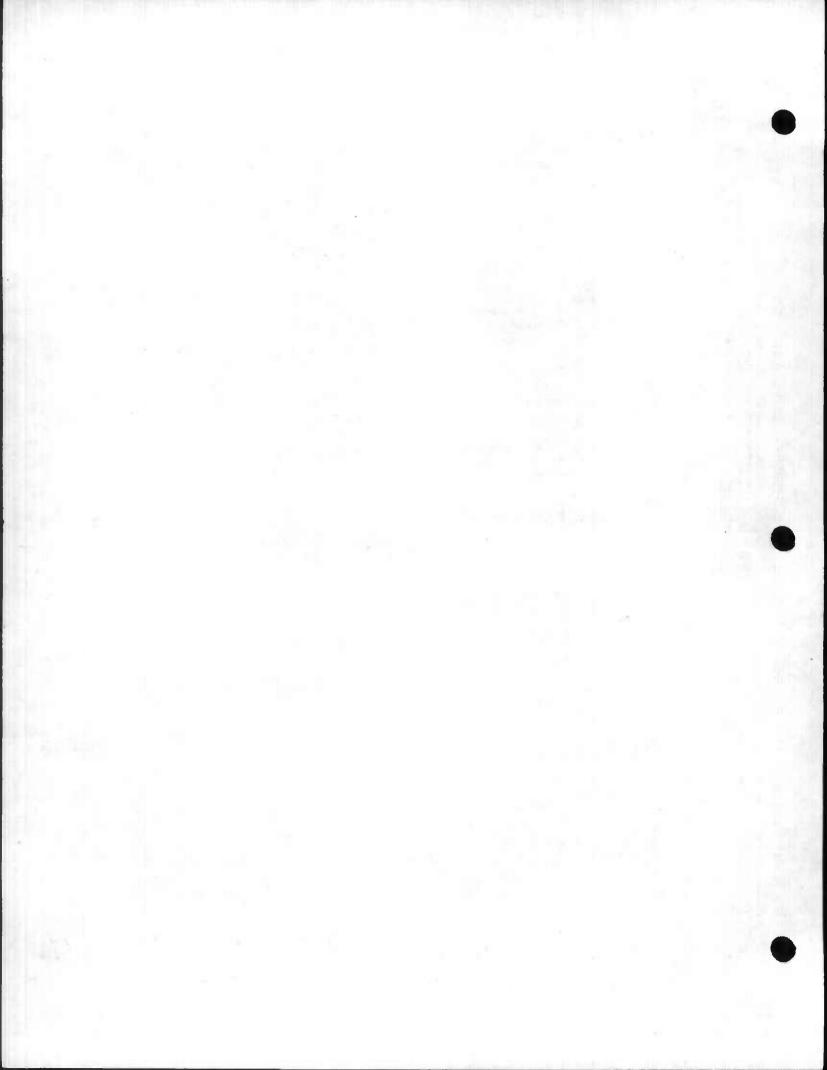
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Medical	_	Lois Ailene	Bliss					Febru	ary 1	6, 1999	7:10
xaminer	ď	4a. Facility Name (If not institution, giv					4b. City, Town,	or Location of Dee	th 4c. C	ounty of Death	
	I,	Shady Grove Ad					Rockvi.		Mo	ntgom	ery
neral	1	5. Social Security Number 6. S	ex 7. Age	(In yrs. lest		If Under 1 Year Months Day		in (Month, D	rth av. Year)	9. Birth	place (Stete or F
ector	1	577-40-7551 Usual Residence of Decedent	A	67	113.			Mar. 2	, 193	I Pen	nsylvan
w	-	10a. State 10b. County		10c. City, T	Town or Loca	ation				Ĭ	10d. Inside City
flest tor	5	Maryland Montgon	nerv	Kens	ingto	n					1 X Yes 2
be nottred Director	5	10e. Street end Number			. 0	10f. Zip Code			10g. Citize	en of What Cou	ntry?
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her then "natural" or items 23a or 28a-f show the Medical Examiner must be notified at Completed by Funeral Director		11. Marital Status	12. Was Decedent E Armed Forces? 1 Yes 2 AN	ver in U,S.	13. Wa	as Decedent o	Hispanic Origin?	(Specify Yes or Netro Ricen, etc.)	0- 14	I. Race - Ameri Black, White	
		1 ☐ Never Married 2 ☐ Married	If Yes, Give	О		□Yes 21XN		,			
		3 ☐ Widowed 4 ☒ Divorced	Year or Dates:	T .						WILLEC	
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other traumatic event, tre M		John Jones					Lillia	n Harris			
armar T		19a. Informent's Name/Relationship (Type, Print (daugh	nter)	19b. Malling	Address (Stre	et and Number or	Rural Route Numb	per, City or 1	Town, State, Zij	o Code)
er tra		Barbara Cathleen						ilver Sp			
or othe	2	20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐		20b. Place	e of Disposit	tion (Name of story or other p	lace)	Date	20c. Loca	ation - City or T	own, State
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any injury or once.		21. Signature of Funeral Service Licen	see	Ones				ices, P.		oville,	
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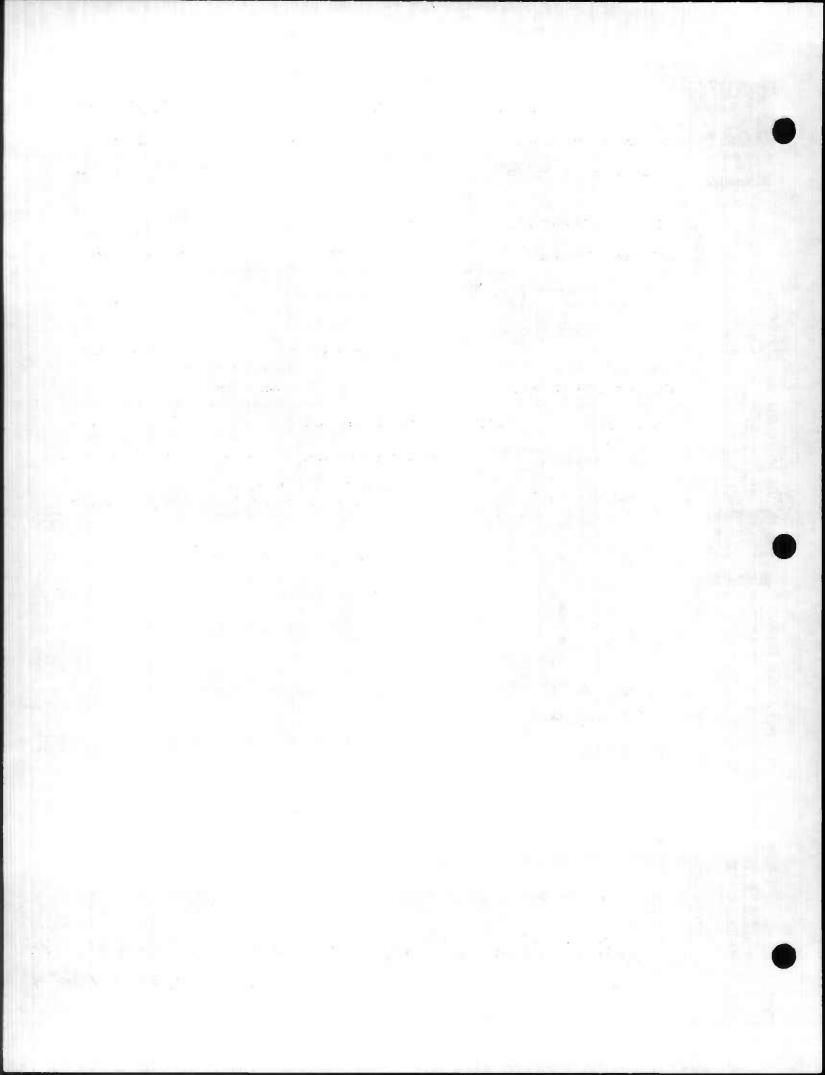
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mt: if it	1 🗷 Burial 2 🗆 Cram: 4 🗆 Donation 5 🗆 Ott		rom Stata Ga		leaven Ce		2/25/99	Silver S	pring, MD	
Departments any injury and and any injury in	21. Signature of Funaral Se	arvice Licensee		Ho	2. Nama and Address ome, Inc.	500 U		Collins Blvd. W	Funeral est	
	23a. Part Lentar tha disea shock, or heart faiture	z complications t	hat caused the de		ilver Spr		20901	rrast	Approximate	A
Physician /Medical Examiner	Immediate Causa (Finel disease or condition rasulting in death)		rter		lerot			isoas	Intervet Bah Onset and D	C8
physician and strength of the burief transit edical Examiner	Sequentially list conditions if any, leading to immadiate ceuse. Enter Undarlying Cause (Disaasa or injury that initiated evants rasulting in death) Last	c		(or as a conseq						
e attending led for use as		d							1	
o atte	Part II. Other significant co	anditions contributing	to death but not r	asulting in the u	inderfying causa gi	ven in Part I.	23b. Dld	tobacco use contr	ribute to the cause of	of death?
signed by the attending I d be detached for use as d by Physician/Me	My	_	tess					./	Probably 4	
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s certificate has director, page 2 To Be Comp	25. Wes cesa refarred to m	edical				26. Place of D	eeth (Check only	one)		
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us or Attending Practice and Director: After the fine of the funeration: Certification:		Could not be latarmined 28a.	Place of Injury - At building, etc. (Spe	t home, farm, str cify)	reet, factory, office			Street and Number wn, Stata)	or Rural Routa Num	ber,
within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Cartifiar (Check only one)	rtifying Physician: To dical Examiner: On t and	the best of my k he basis of exami manner stated.	nowledge, death nation and/or in	h occurred at the ti vestigation, in my	ma, data and plac opinion, daath oc	ce, and dua to tha curred at tha tima,	ceusa(s) and man data and ptece, an	nar as stated. d dua to the cause(s)
Me the	29b. Signature and titla of c	ertifiar 1			29c. Licen	se number		29d. Data signed	(Month, Day, Year)	
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	30. Nama and address of po	/	//		Print) a Dr, Wh	eaton. M	D 20906-	4709		
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Registrar	FFR	3 1999	Gener	v 19.	Spark	2				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 21, 1999 8:45 PM Dorothea Frances Bollegar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not Institution, give street and number) Examiner Wilson Health Care Center Gaithersburg Montgomery Galthers 8. Date of Birth (Month, Dey, Year)
Oct. 15, 1 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2MF Months Days Yrs. 1910 88 577-05-2086 Maryland Director Usuel Residence of Decedent the Marylend 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow 7 is marked other than "natural", or frems 23a or 28a-f shov traumatic event, the Modical Examiner must be notified at 1 N Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 201 Russell Avenue 20877 United States Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 end 2 should be filed within 72 hours after in ant of Health and Mentel Hygiena.
int: If item 27 ie marked other than "natural", or itei 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Office Supervisor Life Insurance 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Father's Name (First, Middle, Last) Be William Albert Clipp Grev Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (POA) 6107 Thayer Street, Fredericksburg, VA 22407 Mark B. Taylor other t 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 6 1 Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: If any Injury or once. 2-24-99 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Rapp Funeral Services, P. A. 23e. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. 933 Gist Avenue, Silver Spring, MD 20910 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final erebnuasc disease or condition resulting in daath) Examiner Examiner per/ension physician end the burial-tran Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Causa (Disaasa or Injury that initiated avants resulting in death) Last Dua to (or/as a consequanca of): tha daath certificate be axed Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 98 attanding i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobecco use contribute to the ceuse of death? signed by 1 Yes 21 10 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy peen 1 Yes 2 100 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 4 hours after death. director, Be 25. Was case referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation 1. Natural 1 Yas 2 🗆 No 2 Accident Director: in by the 3 Suicide 6 Could not be determined 281. Location (Straat end Number or Rural Routa Number, City or Town, Steta) 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Spacify) 4 Homicida Funerel 1 certifying Physician: To the best of my knowledge, daath occurred at the tima, date and place, and due to the ceuse(s) and mannar es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) and manner stated. 29a. Certifian Medical (Check only one) To the Ho within 24 h To the Fur 29b. Stonature 29c. License number 29d. Date signed (Month, Dey, Year) and title of certifier D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. JOHN R.
31. Date filed (Month, Dey, Year) MELNICH MISSELL 911 32. Registrer's Signature State 24 FEB Registrar

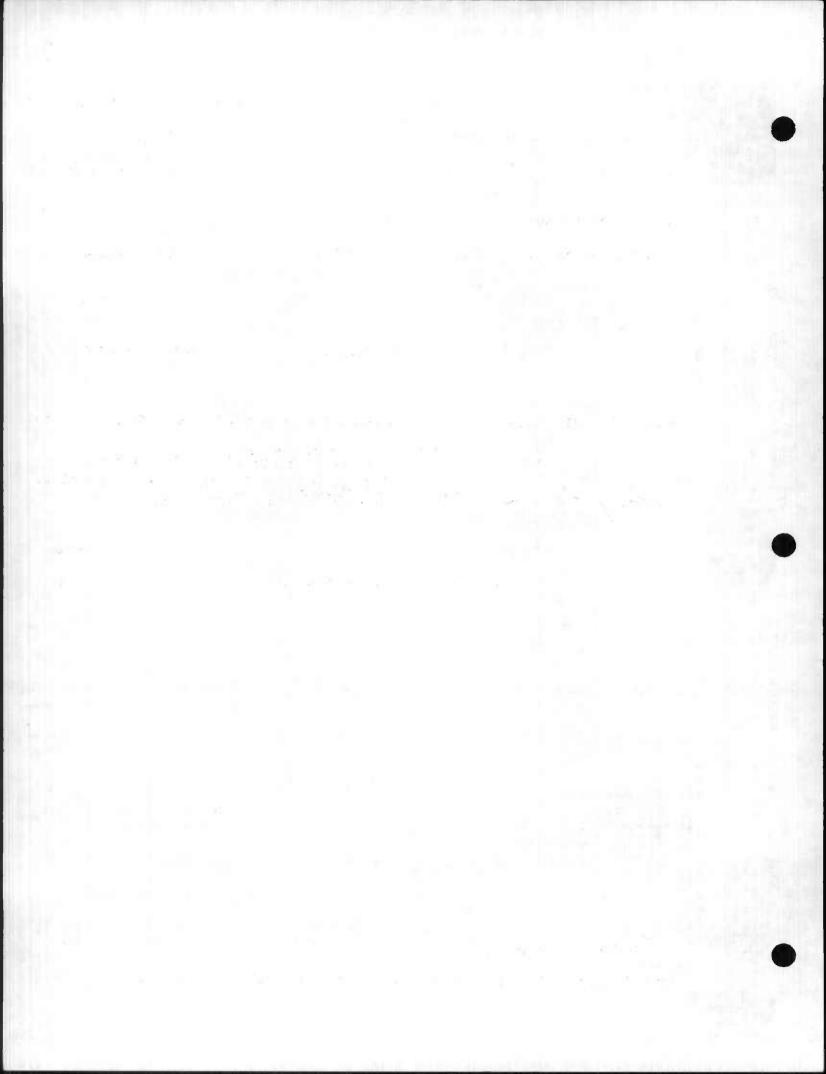


State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death February 21, 1999 **Physician** Ruth Bourne 12:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8100 Connecticut Avenue #1420 Chevy Chase Montgomery If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) July 19, 1907 Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Deys Months 1 □ M 2 🖾 F Hours 103-16-3527 91 Yrs. Massachusetts Director Usual Residence of Decedent the Meryland 10e. State 10c. City. Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Modical Examiner must be notified at 1 Tyes 2 No Directo Maryland Montgomery Chevy Chase 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with 8100 Connecticut Avenue #1420 20815 United States Funerai deeth 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. Pages 1 end 2 should be filed within 72 hours eftar nant of Health end Mental Hygiena. ☐ Yes 2 No f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: by 3 ☑ Widowed 4 ☐ Divorced White Year or Dates Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Health Department 7 le marked other traumatic event, u 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Edward M. Levy 20 Gertrude May Coty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) nt of Health e If Item 27 le or other tra 12708 Hunting Horn Court, Potomac, Maryland 20854 Douglas G. Wadler/Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State State University of New York School of Medicine Feb. 22, 1999 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or 4 □ Donation 5 ☑ Other (Specify)Anatomical Buffalo, New York Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Chase, Inc. Bethesda, Maryland 20814-3501 21. Signeture of Funerel Service Licensee M00198 Pen1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Heart Failure weeks disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Arteriosclerotic Heart Disease 42 years thet the death certificate be executed physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): attending pl for use as t ed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown signed ld be dat Records, þ lew requires 24b. Were autopsy findings avellable prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? peen page 2 has The 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No cartificate Division of Vital Hospital or Attending Physician: director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 10 1⊠ Yes 2□ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 28c. Injury at Work? 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes investigation 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) 5 4 Homicide filled in A 24 ho. 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner as stated. Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D12038 February 21, 1999 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) 10810 Brewer House Road, Rockville, Maryland Marvin Wadler, M.D.

State Registrar

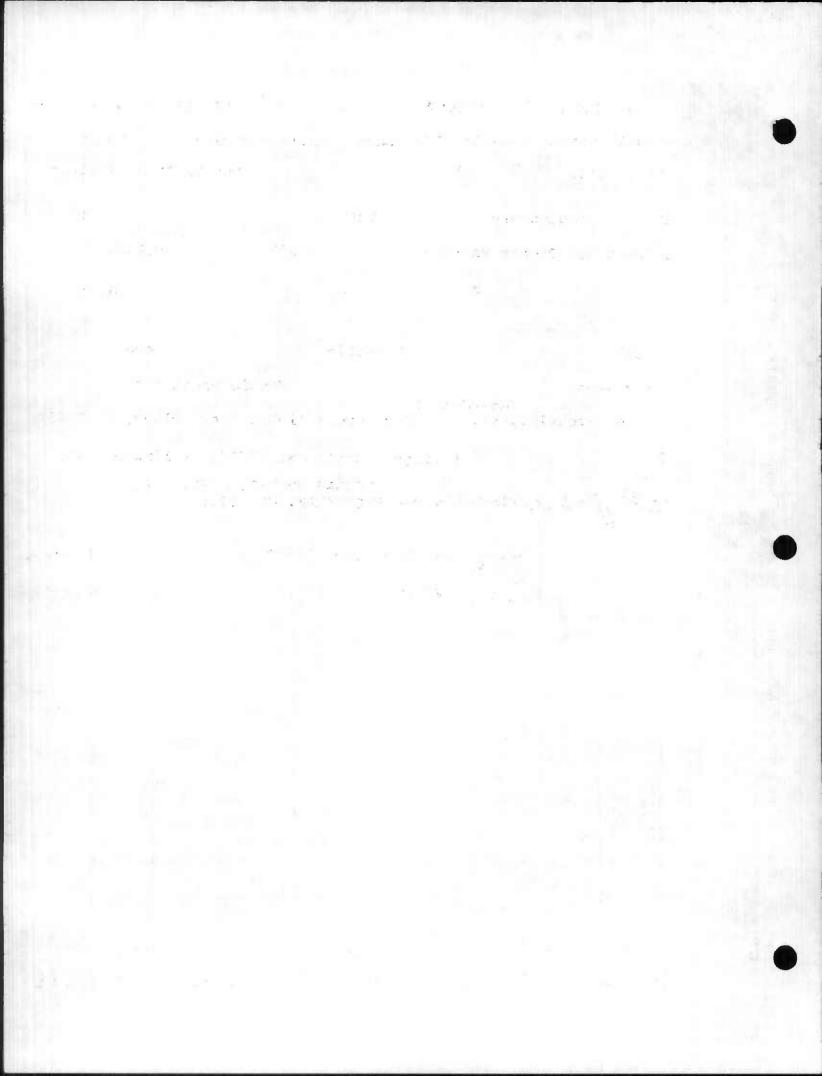
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State of Maryland / Department of Health and Mental Hygiene

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vat be notified at rai Director	10e. Street end Nur 16400		imber Ter	race	10f. Zlp Co	20832		10g. Citizen of What Country? U.S.A.					
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ouce	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850												
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** ROBERT BURKE 11.30 AM FEBRUARY 1999 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SRRING. MONTGOMERY HOLY CROSS HOSPITAL-8. Date of Birth (Month, Dey, Year) If Under 1 Yeer | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** Days Hours Yrs. Director 060-14-9427 Sept 7, 1921 New York New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. tnside City Limits a or 28a-f show 10b. County 157 Yes 2□No Directo Silver Spring | 10f. Zip Code Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number re 23a c Funeral New Hampshire Ave. 20902 U.S.A. Пета 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Amed Follows.
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 ☐ Married 6 1□ Yes 2☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Peges 1 end 2 should be fill ment of Health and Mentel Hant: If item 27 is marked oth jury or other traumatic even 8 UNKNOWN 2 UNKNOWN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Mason / Guardianship 5012 Rhode Island Ave. Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 19,1999 Alexandria, VA Metropolftan Crematory 22. Name end Address of Fecility Washington, DC 20012 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, ordinar failure. List only one cause on each line. Takoma Funeral Home 254 Carroll St. NW Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel RESPIRATORY FAILURE HOURS disease or condition resulting in death) Examiner Examiner HRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest MEARC ONGESTIVE Physician/Medical Due to (or as a conseque Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown by 24a. Wes an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of deeth? Completed 1 ☐ Yes 2 ☑ No 1 Yes 2 No 8 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Inpatient 2□ER/Outpatient 3□ DOA Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of tnjury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. tnjury at Work? 1- Netural 5 Pending investigation 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by

P.O. Box 68760. Division of Vital Records. this or Attending death. 24 hours after deal Funeral Director:

filed within 72 hours efter

Baltimore, Maryland 21215-0020

6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

M.D.

29c. License number 29d. Date signed (Month, Day, Year) 146187

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KURWILLA, M.J. , 11125 ROCKVILLE PIKE, #308, ROCKVILLE, MD P. 31. Date filed (Month, Day, Year)

State Registrar

Medicai

FEB 2 2 1999

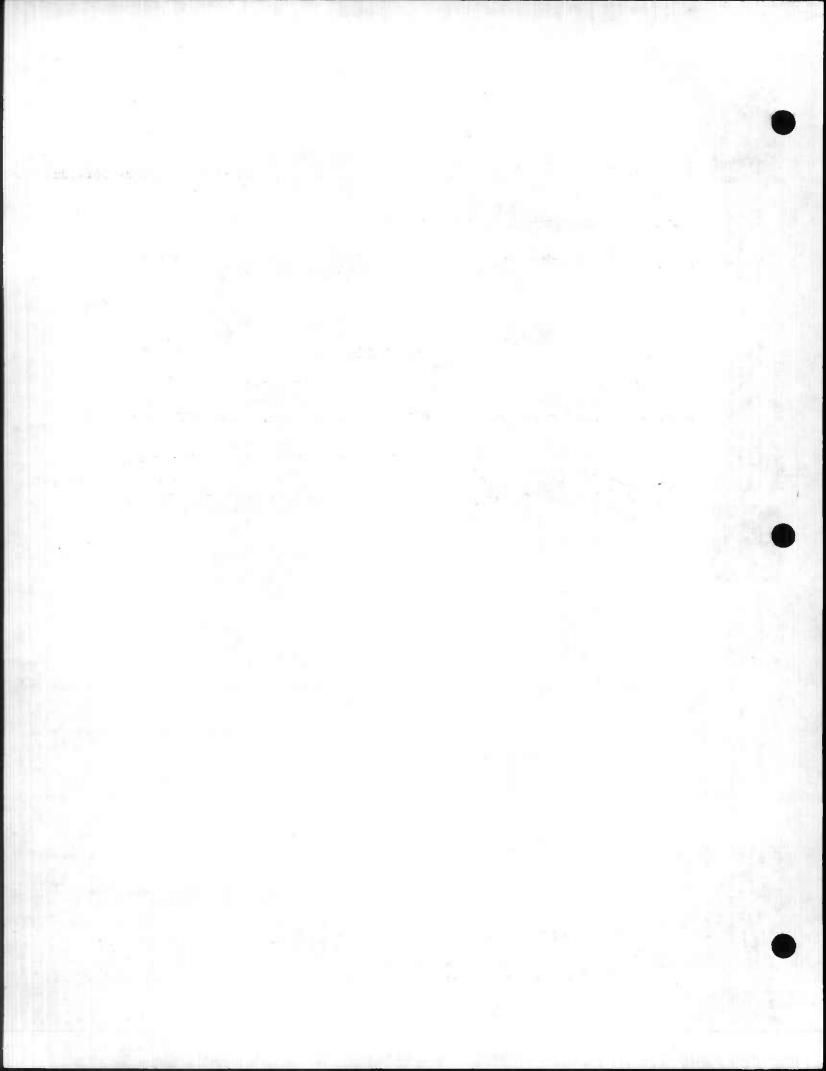
29b. Signeture end title of certifier

32. Registrar's Signature

Hospital

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within 2 \$

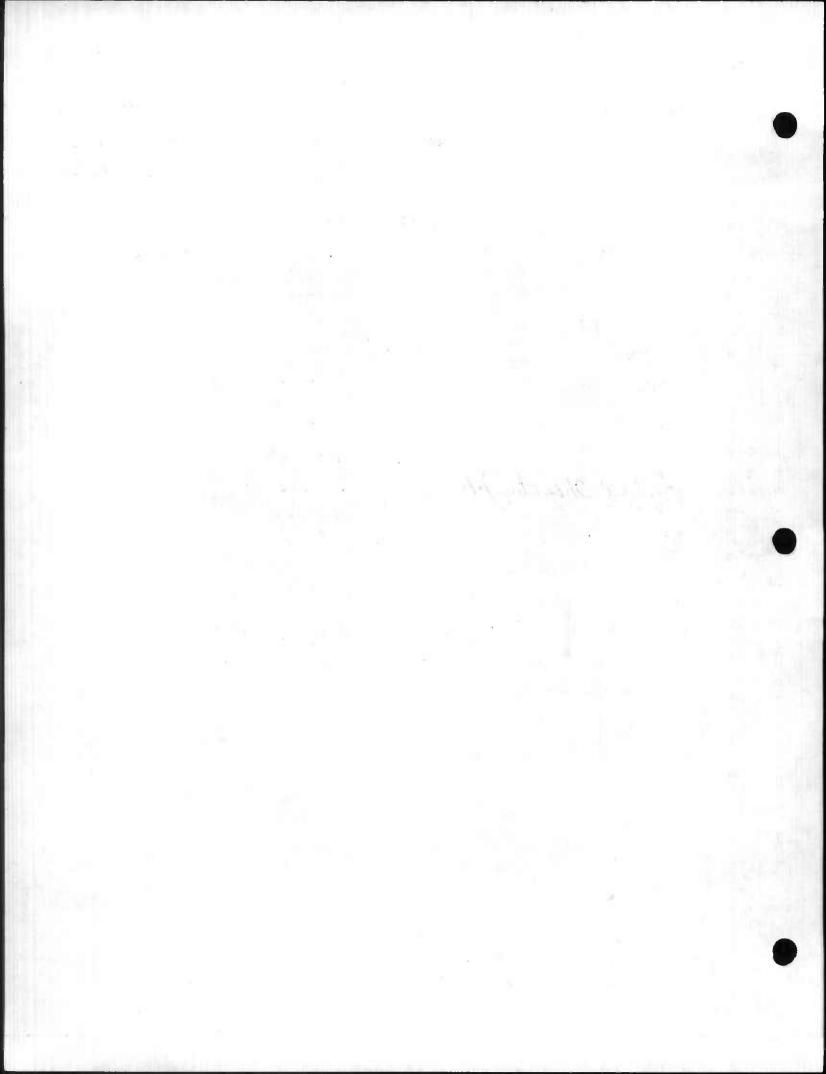


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month **Physician** FEBRUARY 23, 1999 WILLIAM HARRISON BOWMAN 6:12 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE SOUTHERN MARYLAND HOSPITAL CENTER CLINTON 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 □ F Yrs. 80 Director 219-07-4471 APRIL 1918 MARYLAND Usuet Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 25a-f INDIAN HEAD MARYLAND CHARLES 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? res 23a or must be UNITED STATES 20640 6280 STUCKEY LANE Funeral 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Merried b 21215-0020 1 Yes 2 No Specify: Specify: 20 3 Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. PROPELLANT WORKER GOVERNMENT 5TH GRADE Baltimore, Maryland 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental EVA SAVOY BOWMAN ULYSSES H. BOWMAN 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . of Health a If Rem 27 is or other tra VERONICA ELNORA MILSTEAD/DAUGHTER 6674 FENWICK ROAD, BRYANS ROAD, MARYLAND 20616 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremetion 3 □ Removel from State SMITH CHAPEL CHURCH CEM. 2/27/99 PISGAH, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Separare of Funeral Service Licenses 22. Name and Address of Facility dea THORNTON FUNERAL HOME, P.A. PAIL Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

20640

Approximatintervel Bet Approximate Intervet Between Onset end Death **Physician** week /Medical Immediate Cause (Final disease or condition resulting in death) Examine equence of): Examiner dar burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Lest Due to (or as a consequence of) pue mo Box 68760 Physician/Medical Due to (or as h phys. 82.00 use Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, by Pe d 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed The law 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 (Inpatient 2 ER/Outpatient 3 DOA th Is 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation Attending Division 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 6 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifie completely (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20821 unn 30. Name and)edgress of person who completed cause of death (Item 23a) (Type, Print) Marethono Mode 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State **FEB 25** 1999 Registrar



WRC 99-1024-033 MARION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

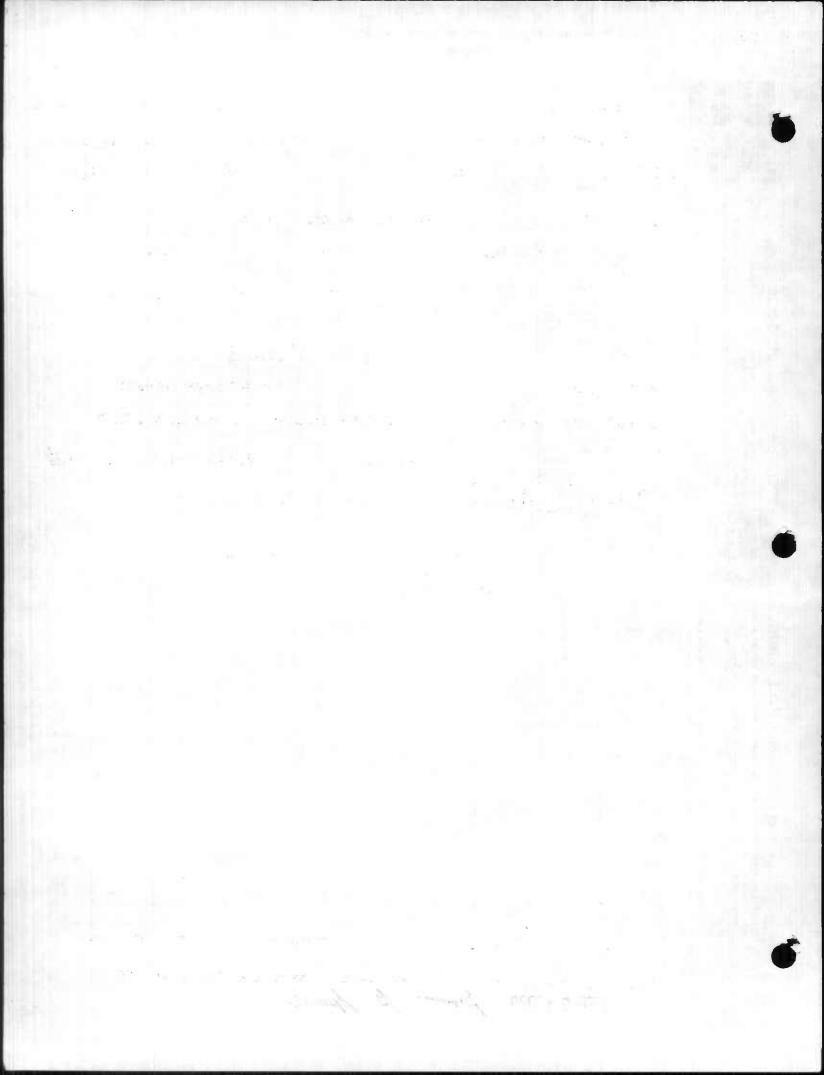
State of Maryland / Department of Health and Mental Hygiene

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ditinonit or modification		

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hysician /Medical	Marion F	eith Baynar	rá				1, 1999	. 041	1:08 PM.
xaminer	4a Facility Name (If not institution, given	ra street and number)			4b. City, Town, o	r Location of Death	4c. County	of Death	
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ral tor	218-70-4118	MA OFF	(In yrs. last birthday 41 Yrs.	Months Day			Year)	9. Birthplace	(State or Foreign
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5	- 0				Dv Cl	inton			ØYes 2□No
Director	Md. P, ()	12031. Bi	10f. Zip Code		inton	log. Citizen of V	What Country?	
by Funeral Director	12031 Birch			2073	35		U.S.		
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Ev Armed Forces? 1 Yes 2 No If Yes, Give Yaar or Dates:		. Was Decedent of If Yas, specify C	uban, Mexican, Pue		Blac	e - American in ok, White, etc. :: Black	dian,
once. To Be Completed	15. Dacedent's E (Specify only highest gr	ducation ada completed)	16a. Dece	edant's Usual Occ	cupation na during most of w ired)	vorking	16b. Kind of Br	usiness/Industr	1
npidu	Elemantary/Secondary (0-12)	Collega (1-4or 5+	iife.	DO NOT use ret	rired)				
Co	12	2	C	impute	1 Net	word			
Be	17. Father's Name (First, Middle, Last)		,		ame (First, Middle,			
1º	Paul Baynard				y Bayna				
	19a. Informant's Name/Relationship		Rural Route Numbe			a)			
	Laura Baynard	(nother)	20b. Place of Disp	22433 Hi		Rd. Dent			Paula
	20a. Method of Disposition 1 Burial 2 Cremation 3	Ramoval from State	cemetery, cri	amatory or other	place)	Date	20c. Location -	,	Stata
	4 □ Donation 5 □ Other (Speci	٤)	SANdto	un		12/27/99	Hills	FORD	Md.
once.	21. Signatura of Funaral Sarvice Lice	and W	2	22. Name and Ad	east (rue :	21601		
	23a. Part1. Entar the disease, or com shock, or heart failure. List only	plications that caused to	he death. Do not en	nter the mode of o	dying, such as card	iac or raspiratory ar	rest,	App	roximata rval Between
a proclam/Medical Examiner	Immediata Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disease or Injury that Initiated events	b. Dee	One to (or as a conse	equence of): Throme equence of):	o-embo	olis m			
Physiclan/Medical	resulting in death) Last Part II. Other algnificant conditions of	d			givan In Part I.	23b. Did t	obacco use co	ntributa to the	cause of death?
by Phys					3	101	res 2□No	3 Probably	4 Junknown
pieted						24a. Was a perfor		availab	utopsy findings la prior to tion of cause 1?
Compl						1084	es 2□No	105×0	s 2 No
Fo Be	25. Was casa rafarrad to madical examiner?				26. Place of D	eath (Check only o	ne)	1	
2	1 XYes 2 No	Hospital: 1 Inpatian	t 2X ER/Outpatie	ent 3LI DOA		Home 5 Resid			
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Sertific	3 ☐ Suicida 6 ☐ Could not be determined	28e. Placa of Injur building, etc.	ry - At home, farm, s (Specify)	streat, factory, offi	Ce	28f. Location (S City or Tow	Street and Numb n, State)	per or Rural Ro	ute Number,
edical	29a. Certifier 1 Cartifying Pl (Check only one) 2 Medical Example (Check only one)	yalcian: To the best of niner: On tha basis of e and mannar state	examination and/or i	ath occurred at the invastigation, in m	a time, date and pla ny opinion, daath oc	ce, and due to the courred at the time, o	cause(s) and ma date and placa,	anner as stated and due to tha	cause(s)
M	29b. Signature and title of cartifier	1 Chute ro		29c. Lie	o.C.M.E.		Ped. Data signa FEB. 22		Year)
State	30. Name and address of person when the state of the stat	complated cause of decomplated	ath (Item 23a) (Type 111 Per	nn Stree	t, Baltim	ore, Mary	land 21	1201	

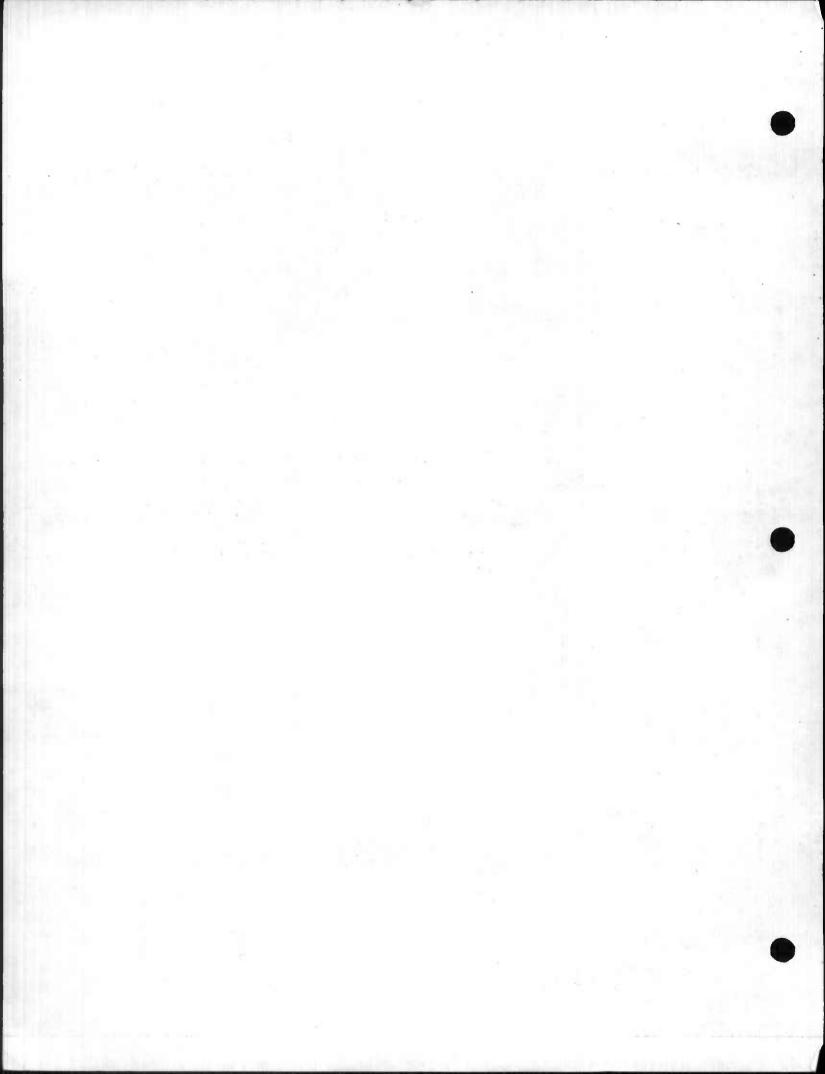
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Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 07 172

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Discontinue	1. Decedent's Neme (First, Middle, Las	1)				2.	Deta of Death Month	Day	Yeer 3.	Time of Deeth		
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Examine	do Casiliba Namo /// and institution with	street and number)			4b. City, To	own, or Locati	on of Death	ath 4c. County of Deal				
	CIVISTA MEDICAL CH	ENTER			LA P	LATA		CHARI	LES			
Funeral Director	5. Social Security Number 176-34-9192 6. Se	9x □ M 2\(\(\Delta\) F \(\begin{array}{c} 7. \text{ Age (III} \\ 55	yrs. last birthday Yrs.	Months	Year If Under Days Hours	Min. NO	Dete of Birth (Month, Day, Y	1943	9. Birthplace Country) Pennsyl	(State or Foreign		
and and	Usual Rasidence of Decedent 10a. Stete 10b. County	10	c. City, Town or L	ocation						nside City Limits		
Many a-f eho	Maryland Charles 10e. Street and Number	5	Port	Tobaco	0				1	□ Yes ¾□ No		
A 28	10e. Street and Number			10f. Zip C	ode		10g	10g. Citizen of What Country?				
th wit	8610 Candon Road			2	0677				USA			
Q Z1Z13-0020 filed within 72 hours after death with the Maryland Hygiene. ther than *natural*, or fleme 23a or 28a-f show ant, tre Marical Extra half must be notified at ant, tre Marical Extra half must be notified at	861U Candon Road 11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 XXVO If Yes, Give Year or Dates:	Armed Forces? If Yes, apecify ☐ Yes 2 (C)No ! Yes, Give 1 ☐ Yes 2 (X)				Yes or No- an, atc.)	14. Reca · American Indien, Bleck, White, etc. Specify: WHITE				
aryland 21215-0020 should be filed within 72 hours aft nd Mental Hygiene. marked other than "naturel", or martic event, the Middell Earth martic event, the Middell Earth	15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12)	ucation de completed) College (1-4or 5+)					16		usinass/industry			
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Maryland 212 d 2 should be filed withi th and Mental Hygiene. T le marked other then traumatic event, tre.	17. Fathar's Name (First, Middle, Last)	17. Father's Name (First, Middle, Last) Marvin D. Rissinger, Sr. 18. Mother's Name (First, Middle, Meiden Sun Pearl Grace Crissin										
Shou nd M	19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Numi						oute Number, C	ity or Town,	Stete, Zip Code	9)		
421 F	Thomas M. Blaser -	- Husband	8610	Candon	Road,	Port T	obacco.	MD 20	0677			
is 1 and if Health Item 27 other t	20e. Method of Disposition	2	Ob. Plece of Disc		of				City or Town, S	Stete		
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D FORES	THE HUNTT FUNERAL HOME, INC.											
	John P. Knisle 23a. Part1. Enter the disease, or comp shock, or heart failura. List only of									roximete		
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	· CAN	CER	0		ER	2	K	Ons	rvel Batwaan et and Death		
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al or Attending P safer death. In Director: After the din by the funera	27. Manner of Death 2 Accident 5 Pending	(Month, Day Ye	At home, farm, s	М	t□Yes 2□		Location (Stree City or Town,	et end Numb State)	per or Rural Rou	ite Number,		
2 - 7 -	29e. Certifier1K1 Certifying Phy	raician: To the best of my	/ knowledge, dea				dua to tha cau	sa(s) and me				
within 2 To the comple		and manner stated.		200 1	icense number		204	Date sions	d (Month, Day,	Year)		
T × T	29b. Signeture and title of certifier Kerific	M. Ma	On) 2 F	352			Y 24, 1			
	30. Nema end addrass of person who c	ompleted cause of death	(Item 23a) (Type	, Print)	3.00	TULL						
	KRISHAN MATHUR, M	D., 3500 OLI	WASHIN	GTON RI	.,WALDO	ORF, MD	20602-	3208				
State	31. Deta filed (Month, Day, Year)	32. Registrar's	Signature	1								



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month MICHAEL ALLEN BARKER Feb. 10, 1999

4b. City, Town, or Location of Death

4c. County of Death 2PM 4a Facility Name (If not institution, give street and number) Queen Anne's Rte.301N at Rolling Bridge Road Centreville If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Steta or Foreign Country) 15₹ 2□ F Months Days 217-31-6816 Jan. 18, 1990 Maryland Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. inside City I lmits Queen Anne's Centreville Md. 1 Yes 2000 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 362 Poplar School Road 21617 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220240 if Yes, Give Yaar or Dates: 14. Race - Amarican Indian, Black, White, etc. 1€ Never Married 2 Married 1 Yes 2€No Specify: Specify: White 3 Widowad 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) (Give kind of work dona during most of working life. DO NOT use retired) Kennard Elem. Elementary/Secondary (0-12) College (1-4or 5+) School Student 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middla, Last) Diane Krausz Seth E. Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 362 Poplar School Road, Centreville, Md. Seth E. Barker (Father) Feb. 15 ate 1999 Location - City or Town, Stata 20b. Place of Disposition (Neme of cametary, cremetory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesterfield Cemetery Centreville, Md. 21. Signature of Funeral Sarvice Licensee 22. Name and Addrass of Facilit Fellows, Helfenbein & Newnam Funeral Home MERCERON CESP 408 S. Liberty St., Centreville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsel and Death Immediate Cause (Final Multiple head + chest injuries MMEDIATE diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy complation of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 AOther (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred M.V.A injury 1 Natural 5 Pending 2:000 2-10-99 1 ☐ Yes 26 Accident 3 Suicide investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Rt. 301 at Rolling Bridge Road at highway intersection 6 Could not be 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certified and manner stated.

Division of Vital Records,

signed by the e phould Sec certificate or Attending Physician: effer death. Director: After this certific funeral director, 24 hours e Funeral C Hospital To the I

Physician

/Medical

Examiner

Director

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Manical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after on or of Health and Mental Hygiene.

Interest I few 27 is marked other than "natural", or the interest or other traumatic event, the Marital Expension into or other traumatic event, the Marital Expension.

permit. Page Department of Important: If any injury or page.

Physician /Medical

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To

Certification:

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Maryland 21215-0020

Baltimore.

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death

State Registrar 31. Date filed (Month, Day, Year) FEB 1 6 1999

MAR A

Ralph E.

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30. Name and address of person was completed ceuse of death (Item 23a) (Type, Print)

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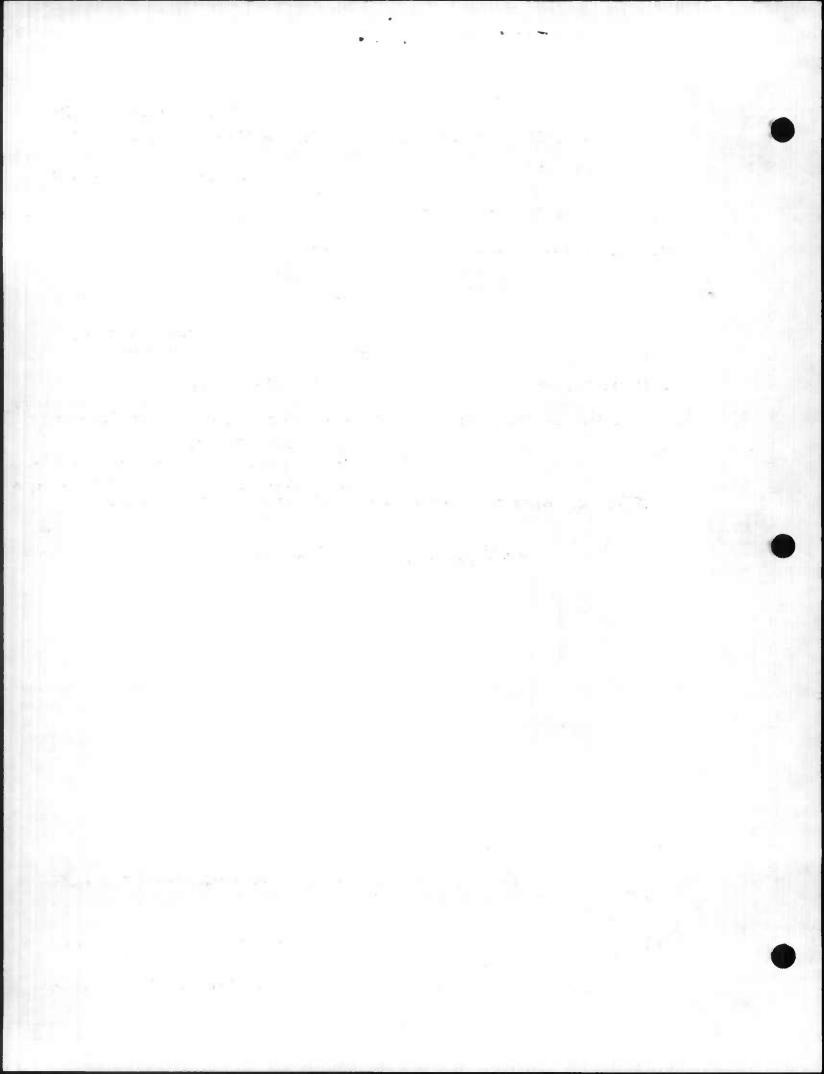
M.D.; 204 Medical Center Rd., Grasonville, Md. 21638 32. Registrar's Signature Geneva

Sporks

29c. License number

D000 5754

29d. Date signed (Month, Dev. Year)

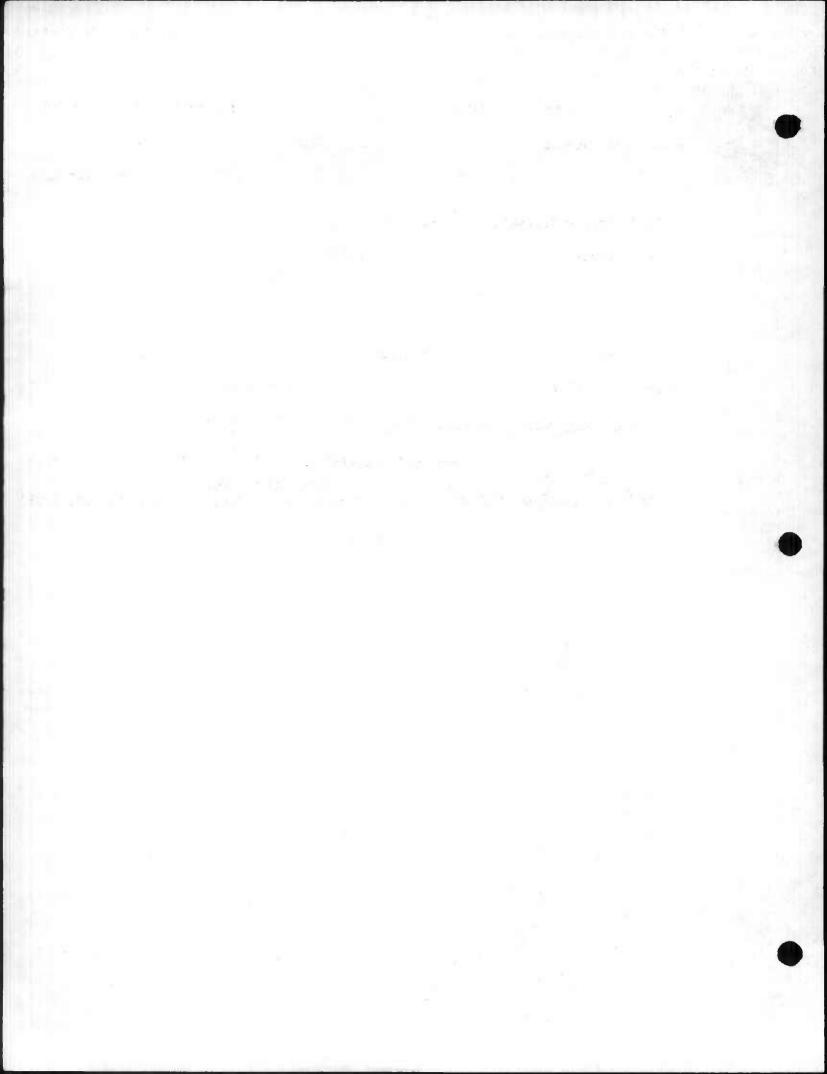


State of Maryland / Department of Health and Mental Hygiene 9 9 7 7 7

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ıysician Medical	_	Olive J. C	hertoff							Feb.				2:15AM
kaminer		4e. Facility Name (If not institution,	Zalar and Taran					4b. City, To	wn, or Lo	cation of Dee	th 4c. (County	of Death	
		Shady Grove A	Adventis	st Hos	pital	- Hardeley	and the same	Rocky				lont	gome	ry
neral ector		577-34-6145	6. Sex 1 □ M 2 2 F	7. Age (In yrs 83		Month:	der 1 Year ns Days		Min.	8. Date of Bi (Month, D April	irth ay, <i>Year)</i> 27, 1	915	9. Birthplac Country, Washi	e (State or Ford) ngton,
-	-	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or I	Location							10d.	Inside City Lin
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niner must be notified Funeral Director		4978 Sentinal D	r. #106				Zip Code 1816				U.S		hat Country	7
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Physic		MARY LUCILI	.E	CAIN					Fe	Month ebruary	Day 18, 19	year 999	8:00 P	M
/Medi Exami		4a. Facility Name (If not institution, gi						4b. City, Tov		tion of Death	4c. County			
LAUIII	1101							Potoma	20		Montgo			
Funeral		Manor Care Potoma 5. Social Security Number 6.		. Age (In yrs. lest	birthday)	If Under 1		if Under 2		Date of Birth	0			Foreign
Director			1□ M 2□XF	82	Yrs.	Months [Days	Hours	Min.	Date of Birth (Month, Day, pril 22	Year) 1916	West	lace (State or F try) : Virgi:	nia
laryland standard	ŏ	10a. State 10b. County		10c. City, To								10	0d. Inside City	
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23a or	Funeral Director	7009 23rd Place				10f. Zip C	783				U.S.A.	Vhat Coun	try?	
TOTALITHOPE, MISTYISHING ZIZID-UUZU permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any lidury or other traumetic event, the Medical Examiner must be notified at any lidury or other traumetic event, the Medical Examiner must be notified at any Bobbs.		11. Marital Status 1 Never Married 2 Married	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give	es? Ty No	l li	Was Deceder f Yes, specify I □ Yes 25	y Cuba	lispanic Orig an, Mexican Specify:	gin? (Specil , Puerto Ric	ly Yes or No- can, etc.)	an, etc.) Biack, Whi		etc.	
ural'	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dat								оросу	Whi	.te	
Maryland 41215-UUXU td 2 should be filed within 72 hours ef tht and Mental Hygiene. 77 Is marked other than "natural", or traumetic event, the Medical Exam	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ada completed) College (1-4		6a. Deced (Giva : life. E	lent's Usuai (kind of work DO NOT usa	done c ratired	eation during most d)	of working	1	6b. Kind of Bu	ainess/Ind	lustry	
N Signatura	NO.	12 Years			House	wife					Own Hor	me		
of H	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (/	First, Middla, M	laidan Sumam	e)		
A pind by the state of the stat	To	Marion Lewis Wolfe	2					E1:	la Es	kew				
2 shot and h		19a. tnformant's Name/Raiationship	Type, Print)	1						Routa Number,	City or Town,	Stata, Zip	Code)	
and and a 27		Marcia Lynn Cain	Coling, I	aughter	182 Ar1	3 Nort	th n	Virg	ord S inia	22207				
T T T T T T T T T T T T T T T T T T T		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Damauai from Ca	20b. Place ceme	of Dispos etery, crem	ington sition (Name natory or other	of er plac	(xe)	100 11	Date 2	Oc. Location -	City or To	wn, State	
Pag nent int: I		4 □ Donetion 5 □ Other (Speci		Natio	onal	Memori	ial	Park	/22/1	999 Fa	11s Ch	urch,	Virgi:	nia
permit. Pages 1 at Department of Hee Important: If Item: any Injury or other 200ce.		21. Signature of Funeral Service Lice	0 /	1	TA	Name and A	Addre FUN	ss of Facility ERAL	номе,	INC.				
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Examiner		resulting in daath)	a	Due to (or as	- 0	uence of):								
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aw requires to the second of t	Completed									24a. Was an perform		con	re autopsy find iliable prior to inpletion of cau laath?	
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ysician: The securificate director, pag	Be (25. Was casa referred to medical examinar?						26. Place	of Death (Check only ona)			
Physic this ce	To	1 Yas 2 No	Hospitai:	patient 2 ER/	Outpatient	t 3 DOA	Oth	er: 4 Nui	rsing Home	5 Residan	nce 6 Othe	er (Specify)	
Attending Physician: or death. ector: Atter this certific by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Panding 2 ☐ Accident invastigation		Injury 28t Day Year)	o. Tima of tnjury	28c	Injur Wor		286	d. Describe hov				
To the Hospital or Atlending Ph within 24 hours eller death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 4 Homicide Could not be determined	e 28e. Piace of	Injury - At home, etc. (Specify)	, farm, stre	eet, factory, o	office		281	Location (Stre City or Town,		er or Rurel	l Route Numbe	W.
To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one)	yalctan: To the be niner: On the basi and manna	s of examination	lga, daath and/or inv	occurred at restigation, in	the tin	ne, date and pinion, deat	d place, and h occurred	d due to the cau at the time, dat	use(s) and ma te and piace, a	nner es sta and dua to	ated. the causa(s)	
omp omb	Me	29b. Signature and title of certifier	1/ /	1.		29c. L	Licens	e number		29	d. Date signed	(Month, E	Day, Year)	
5		Mille	nmi	unso		7	5	128	0		ソー ス		State and State	
		30. Name and addrass of person who	complated causa	of daath Item 23	a) (Type, f									
		13214 13 XECUT	102 PM	K TEER	IL VES	2 0	1 72 6	SOAN.	1000	N HE	33 C	74.		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 3 19		istrar's Signature	L	1								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 20 Day Month **Physician** 1999 7:05 AM Harriette Chaitt /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Death Examiner Potomac Nursing Center Rockville Montgomery 5. Social Security Number 179–26–4440 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 14 1914 Birthplace (State or Foreign Country)
 New York 7. Age (In vrs. last birthday) 6 Say 1□M 2XF Months Days Hours 85 Yrs Director Usual Residence of Deceden 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits Yes 2 No MD Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4800 Hamdon Lane 20814 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2000 Specify: White Specify: by 3 ∠Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clothing Retailer Garment Industry 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Alpert Lena Maltz 19a. Informant's Name/Relationship (Type, Print)
Daugnter-in-19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Sandy Rothman/ Law 4800 Hamdon Lane, Bethesda, MD 20814 20e. Method of Disposition 20b. Placa of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/23/99 Miami, FL Woodlawn Cemetery 22. Name and Address of Facility Takoma Funeral Home 254 Carroll Street, Washington, DC 20012 Kauken 23a Part Enter the disease, or complications that caused the ceeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock from failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediete Ceuse (Final aCONGESTIVE HEART FAILVRE

Due to (or as a consequence of): WEEK disease or condition resulting in death) Examiner ARTERIOSCLEROTIC HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Physician/Medical Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autoosy Completed performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be To Other: 45 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide

physician and s the buriel-trans Box 68760 ettending p been signed by should be detact peen certificate Division of Vital Attending Physician: this After or Attending after death. Director: Aft To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th

Funeral

7 is marked other than "naturel", or items 23a or 28a-f show trsumstic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be liled within 72 hours eiter Depertment of Heelih end Mentel Hyglene. Important! If Item 27 is marked other than "naturel; or ite any injury or other traumatic event, tra Manical Espaning

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

the Marylend

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier

TX Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and tale of contrib

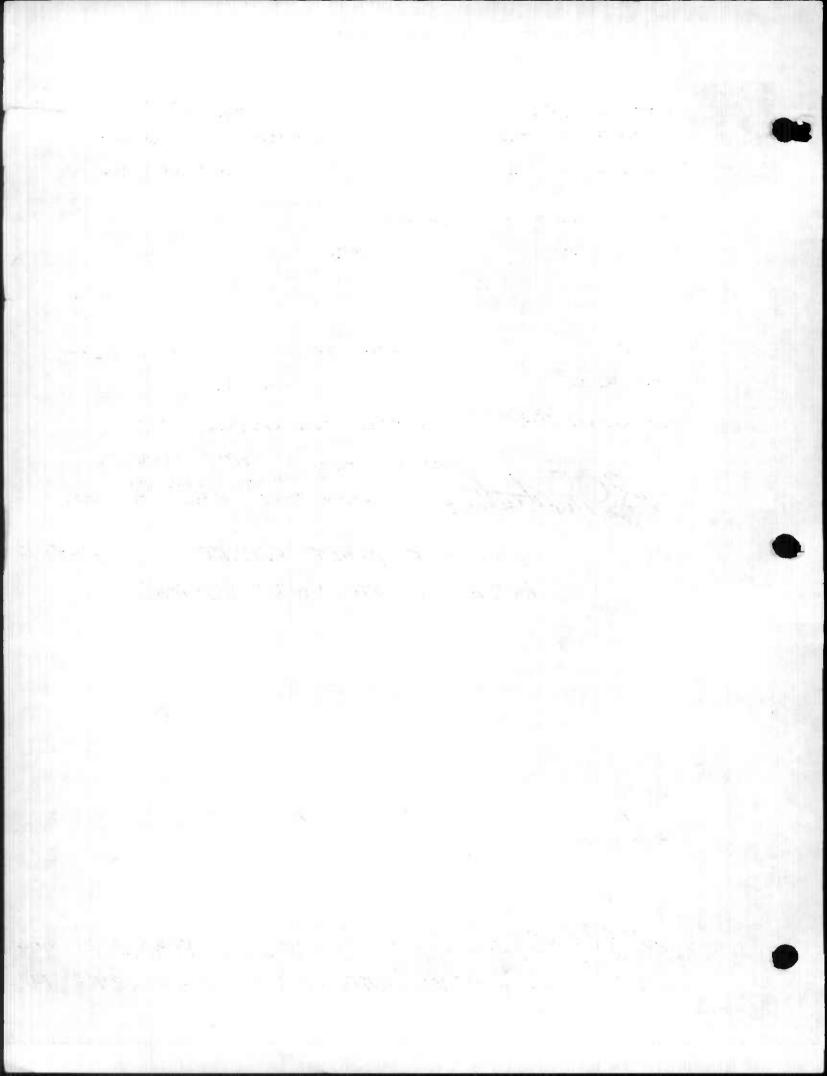
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

MY 1299 HAMBERTOW DRIVE SILVER SPRING G002H

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 23 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death CHARIG Month GERARD February 18, 1999 6:38 P.M. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) XX M 2 F Deys Hours Yrs. 79 073-14-7480 August 22, 1919 Germany Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5450 Whitley Park Terrace, # 111 20814 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? XIX Yes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5 Years Lawyer U.S. Dept of Justice 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Alfred Charig Henrietta Maisner 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mark Smotkin-Son-In-Law 10705 Balantre Lane, Potomac, Maryland 20854 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) King David Mem. Garden 2/21/99 Falls Church, Virginia 21. Signature of Funeral Service Upensee 22. Neme end Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Md. 20852 23a. Pert1. Enter the c shock, or heart fi en or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, with only one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Ceuse (Finel disease or condition resulting in death) Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 28 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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After this

Director:

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Hospital c To the Hospital within 24 hours e To the Funeral L

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Febuary 18, 1999

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Examiner

Physician/Medical

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Certification:

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Physician

/Medical

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Funeral

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7 is marked other than "natural", or flems 23s or 28a-f show traumetic event, the Medical Examiner must be notified at

the Maryland

with

death

filed within 72 hours efter

permit. Pages 1 and 2 should be filed within Department of Heelth and Mentel Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event. If Item 11 is 11 in 11 in

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest

26. Plece of Death (Check only one)

25.	Was case exeminer?	referred	to	medical
	1 Yes			
27	Manner of	Deeth		

1 Naturel 2 Accident 5 Pending investigation

28b. Time of

Impatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

6 Could not be 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only

3 ☐ Sulcide

Confifung Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

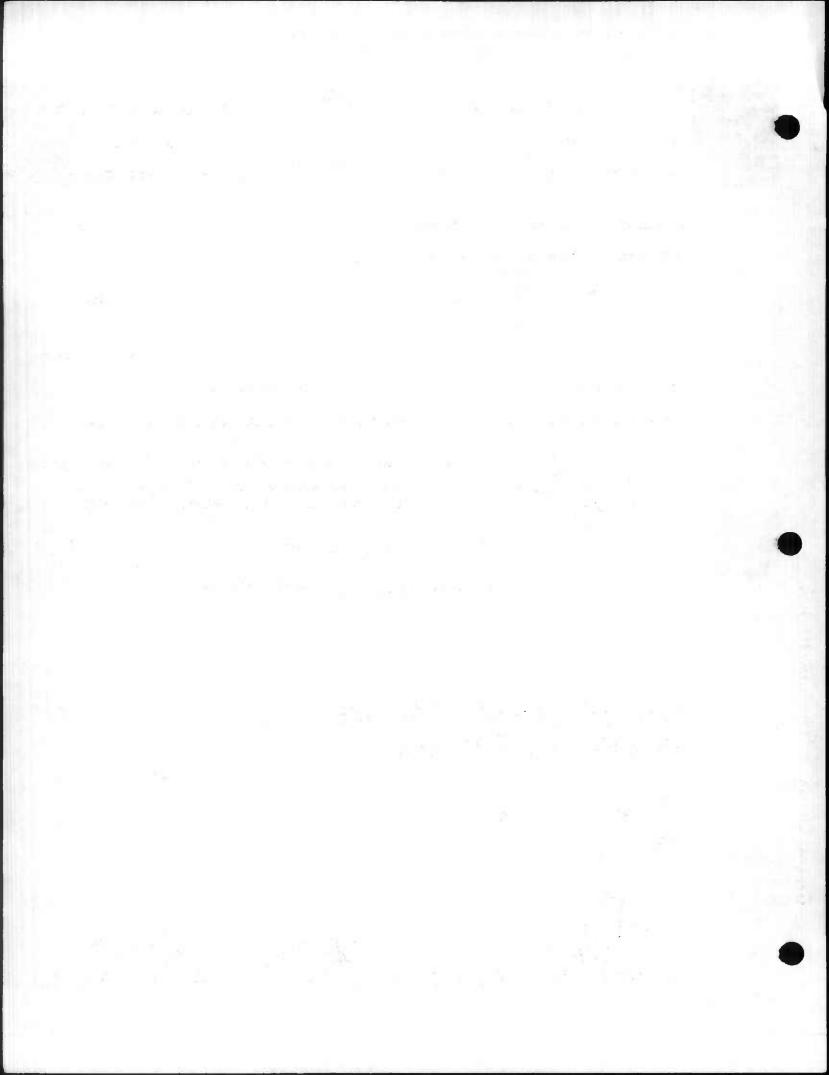
29b, Signate

29c. License number

29d. Date signed (Month, Dey, Year)

Registrer's Signeture Royer

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Albert J Cissel, JR. Month 2415 5:20 Am 10,99 February /Medical 4a. Facility Name (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster County Carroll If Under 1 Yaar | if Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) Funeral Birthplece (State or Foreign Country) 1⊠M 2□ F 216-24-0894 79 Director Aug. 14 1919 Maryland Usuai Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits Maryland Montgomery Director Gaithersburg 1 ☑ Yas 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ò 415 Russell Avenue, 20877 United States Herrie 23a 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No It Yes, Give Yaar or Dates: 14. Race - Amarican Indian, Black, White, etc. Was Decadent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) filed within 72 hours efter 1 ☐ Navar Married 2 Married Baltimore, Maryland 21215-0020 White 'natural', or 1 ☐ Yes 2 SiNo Specify: py Specify 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade complated) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 100 Farm Farmer Defemit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event other. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert. J. Cissel. Sr. Lula Ward 0 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth S. Cissel / Wife 415 Russell Avenue, #416 Gaithersburg, Md. 20877 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriai 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 2/25/99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Servica Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximata Intervei Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical STROKE One DAY Examiner Due to (or as a consequenca ot): Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury Due to (or as a consequenca ot): The law requires that the death certificate be that Initiated events resulting in death) Last Dua to (or as a consequanca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? heart 1 Yes 25 No 3 Probably 4 Unknown Division of Vital Records, fibrillation, Schizo 24b. Were autopsy findings available prior to completion of cause ot death? 24a. Was an eutopsy performed? pertengion 25. Wes case reterred to medical examiner? To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifics completely filled in by the funeral director. Be 26. Place of Deeth (Check only one) 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Investigetion 1 ☐ Yes 2 ☐ No 6 Could not ba determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homicide Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to tha cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

200 memorial Ave, Westmins

29d. Date signed (Month, Day, Year)

Registrar

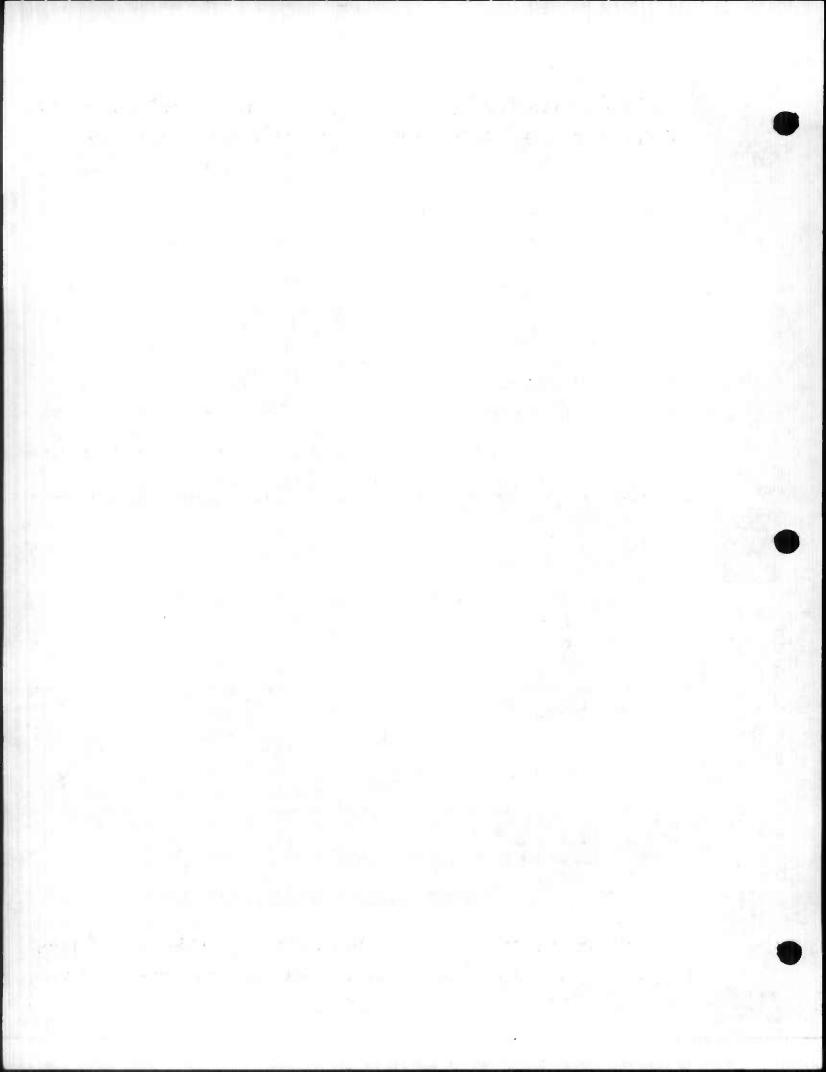
29b. Signature and fitte of certifier

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32. Registrar's Signature

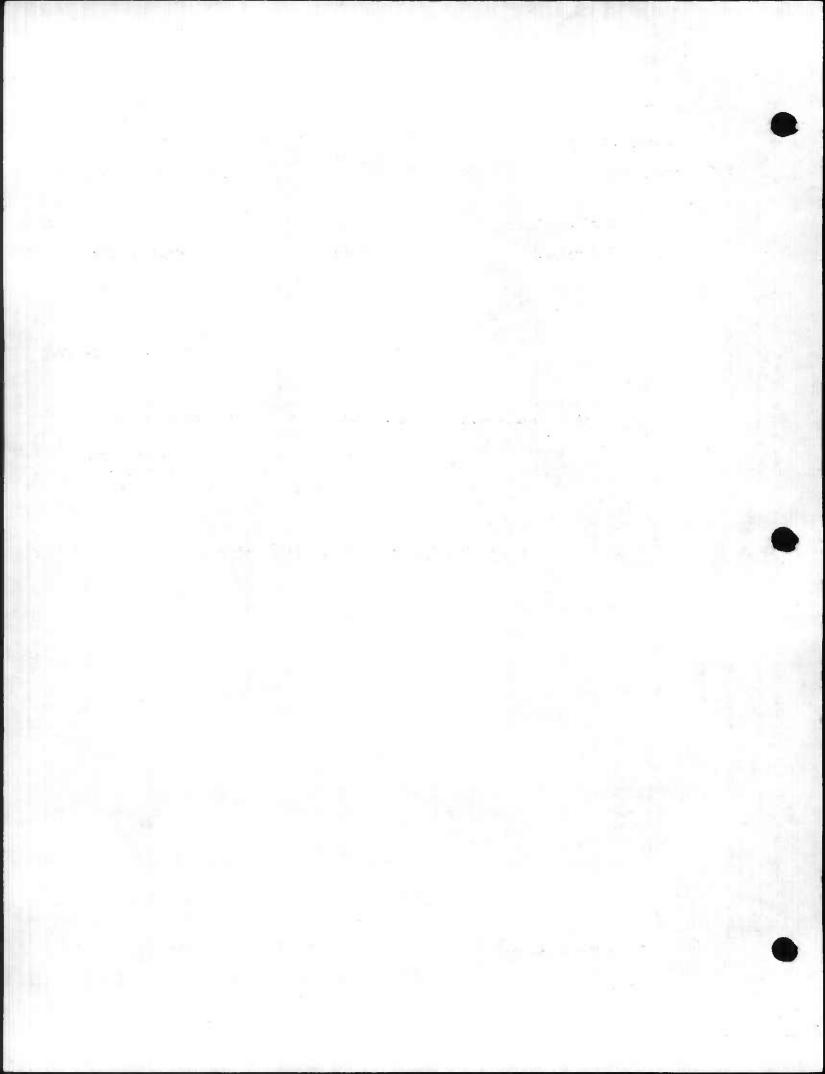
30. Name and address of person who completed cause of death (Item 23e) (Type, Pnnt)

30A

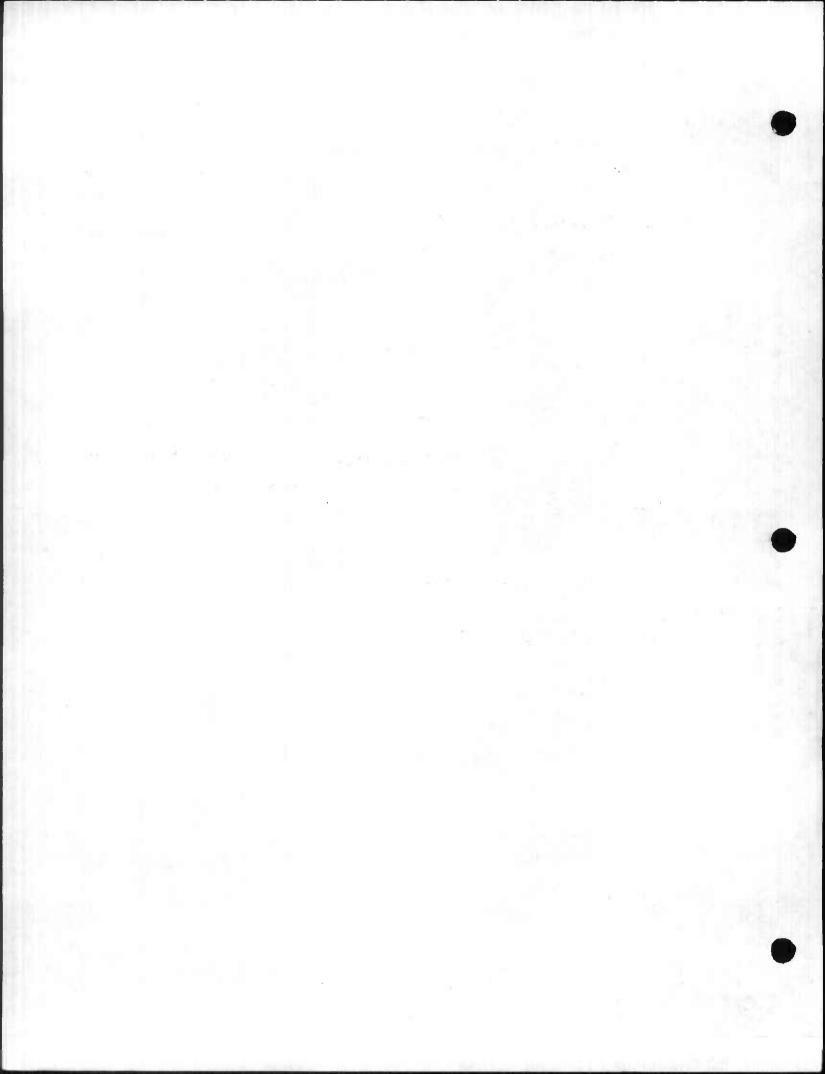


State of Maryland / Department of Health and Mental Hygiene 9 9 7 1 7 9

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Examiner	4e Facility Name (If not institution, give street end number)			4b. City, Tov	wn, or Lo	cation of Death		nty of Deat		
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Menta arked To E	JULIUS COHEN			YETTA	-					
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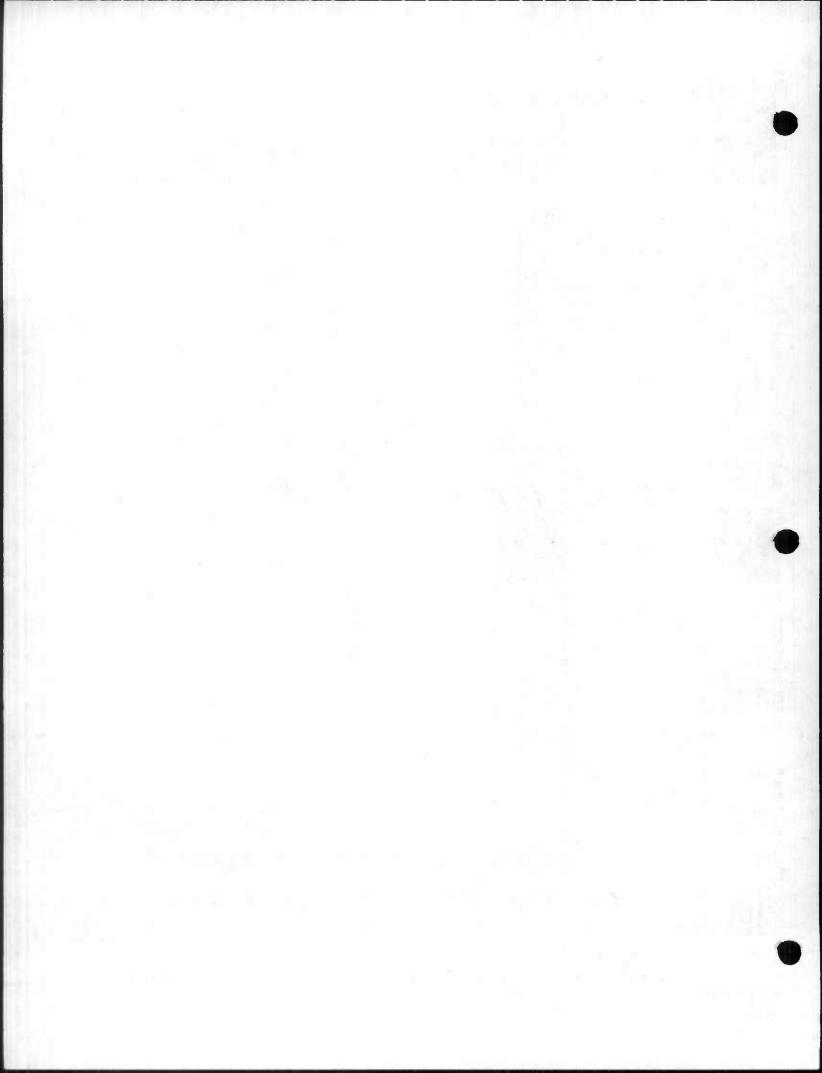


	Decedent's Nama (First, Middle,	0/ 1	Death	2. Data of D	Reg. No.		3. Time	of Death			
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	23a. Part1. Entar the disease, or c shock, or heart feilure. List or	omplications that caused	the death. Do n	ot enter the mode	of dyin	g, such as cardiac	or respiratory	arrest,		Approxime	eta
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- F	27. Manner of Deeth	28a. Date of Inju	ry 28b. T					how injury occu		77	
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W Somp	29b. Signeture and title of certifier	1		29c.	Licens	e number		29d. Date sign	ed (Month,	Day, Year)	
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	7				002.			rebrual	3 19,	1995	
	30. Name and address of person wi			•		11000 -	1			00	
	Lewis N. Cahill			ive Blvd	• , ;	#300, Roc	kville	, Maryla	nd 2	0852	
	04 D-1- 44 1 444 - 11 D . W . 1	22 Decisto	ar's Signeture								
State	31. Date filed (Month Bay, Year)		was signature	G. Spo							



State of Maryland / Department of Health and Mental Hygiene

					Ce	ertificat	e of		·······································	Reg. No.	U	/181
Physic /Medi		1. Decedent's Name (First, Middle, WILLA CHRIS		NEY		The same	1		2. Dete of De Month FEB .	Dey	Yeer 999	3. Time of Death 5:10 Al
Exami		4e. Fecility Neme (If not institution,						4b. City, Town, or		4c. County		
Funcial		CUMBERLAND N 5. Social Security Number		NTER ge (In yrs. le	st birthday) If Under	r 1 Yeer	CUMBERI If Under 24 Hrs			EGAI	
Funeral Director		232-54-4458 Usuel Residence of Decedent	1□ M 2∏ F	74	Yrs.	Months	Deys	Hours Min.			MARY.	plece (Stete or Fore htry) LAND
yland		10e. Stele 10b. County		10c. City,	Town or L	ocation.					1	0d. Inside City Lim
e Mar	Director	MD ALLEC	GANY	CUI	MBERL	AND						1 X Yes 2□1
th with th	al Dire	10e. Street end Number 205 GREENE STRE	CET			10f. Zip 21.	Code 502			10g. Citizen of V U.S.A		ntry?
filed within 72 hours efter death with the Maryland Hygiena. ther than "natural", or items 23a or 28e-f show out, the Medical Example regular and the models.	by Funeral	11. Maritał Status 1 ☐ Never Married 2 ☐ Marrie 3 🌠 Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces 1 Yes 2 If Yes, Give X Year or Detes:		5. 13.	Wes Deced if Yes, spec		dispenic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No to Ricen, etc.)		e - Americ ck, White, /: WH.	
d 2 should be filed within 72 hours of the and Mental Hygiens 17 is marked other than "natural", or traumatic event, the Medical Exerc	Completed	15. Decedent's (Specify only highest Elementery/Secondery (0-12)	Education grade completed) College (1-4or	5+)	(Give	edent's Usue e kind of wo DO NOT us NER/OI	rk done se retire	during most of word)	rking	16b. Kind of B		dustry
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		JEFFREY H. CARN	IEY / SON					L SOL WA	Y, ELK	EROVE, C	A 9	5758
Se lo La		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		1		osition (Nen emetory or o -ROCK			Date 2/24/99	20c. Location -		,
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uted	Examiner	Sequentially list and disland	b	Due to (or	ac a conce	quence of):						
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the ette	sicia	Pert II. Other significant conditions	contributing to death b	ut not result	ing in the	underlying ca	ause giv	ren in Pert I.	23b. Did	tobacco use co	ntribute to	the causs of deat
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying I	Physician: To the best of aminer: On the basis of and menner stope	exeminetlo	edge, deet n end/or in	h occurred envestigetion,	et the tir In my o	ne, date end piece pinion, deeth occu	, end due to the rred et the time,	ceuse(s) end me dete end piece,	nner es st	eted. the ceuse(s)
To the Within 2 To the comple	Me	29b. Signatury and title of certifier				29c	. Licens	e number		29d. Dete signed	d (Month, i	Dey, Year)
4		30 Name and addition of any	a completed course of	anth /lterr	120\ /T)332	280		FEB. 2	1,19	999
ms		30. Name and addfess of person wh SUNIL GUPTA,					JE,	CUMBERI	LAND, M	ID 215	02	
Sta	te	31. Dete filed (Month, Dey, Year) FFR 2.3 10	32. Registro	er's Signetu	re &	,						



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month Yeer **Physician** Richard Lee Conant Feb. 13 1999 5:25 AM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 110 Baltimore Road Stevensville Queen Anne's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In vrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Days 1 X M 2 □ F Months Hours Yrs. 228-24-1224 **Director** Sept. 23, 1931 Maryland Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Il important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar must be maritied. 10c. City. Town or Location 10d. Inside City Ulmits 10a Stete 10h. County 1 ☐ Yes 2 ☐ No Director Queen Anne's Stevensville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 110 Baltimore Road Funeral 21666 U.S.A Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Meritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Yeer or Dates: Korean Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Retail 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be 10 Asa Lee Conant Viola Conner 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Elizabeth Ann Conant Wife 110 Baltimore Road, Stevensville, MD 21666 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Feb. 15 1999 1 ☐ Burial 2 X Cremation 3 ☐ Removel from Stete Chesapeake Cremation Center LLC 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD 22. Neme end Address of Facility 21. Signeture of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619 complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, only one cause on each line. Approximete Intervel Between Onset end Deeth 23a. Part1. Enter the disease, or cond shock, or heart feilure. List only **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Que to (or es e consequence of): Physician/Medical Examiner Ca attending physician and for use es the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest a consequence of) Box 68760 Due to (or es e consequence of) P.0. ed by the a 23b. Did tobecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probabiy 4 Unknown signed b Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? been signated 24e. Wes en eutopsy performed? Completed page 2 s 2 -No 1 Yes 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics complately filled in by the funeral director, to 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 3□ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner es steled.

2 Medical Exeminer: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner stated. 29a. Certifier edicai (Check only one)

MI

Ridgely

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32. Registrer's Signeture

Japan

Avenur

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29d. Date signed (Month, Day, Year)

Soite 23/ Annapolis, no 21041

State Registrar

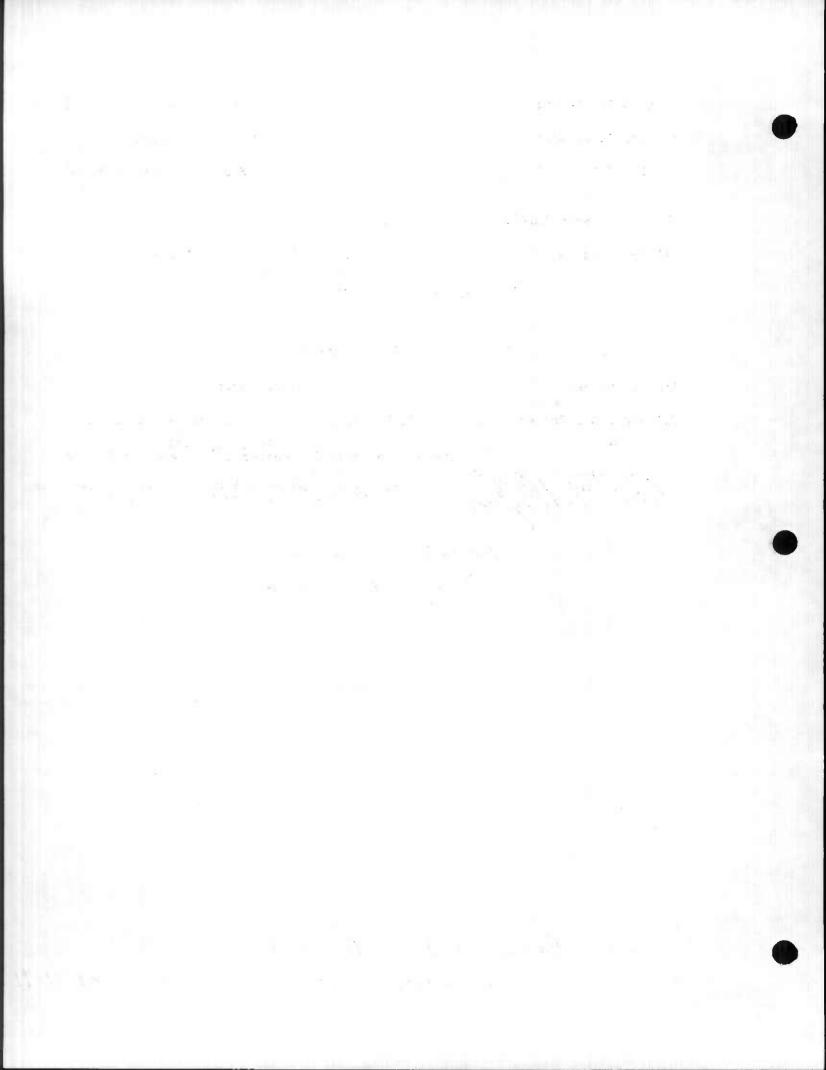
29b. Signeture end title of certifier

31. Date filed (Month.

tarns,

1 6 1999

Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 850 AM Anna NMN Drager e 4e Fecility Neme (II not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Washington County Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□M 2XF 91 Yrs. 135-54-9725 Sept. 12, 1907 Missouri Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Co. Hagerstown 1 Yes 2 No 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 147 King Street 21740 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, While, etc. 11. Meritel Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married White 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Cook Private Residences 5 0 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Eva Bergauer Mathias Reitz 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William L. Drager/Son 20132 Clay Road, Hagerstown, Maryland 21742 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Rest Haven Cemetery Feb. 22 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Douglas A. Fiery Funeral Home 1331 Eastern Blvd, N., Hagerstown, Maryland 21742 21. Signeture of Funeral Service Licensee aucho 234. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) ero Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 NO 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Examiner Records, P.O. Box 68760 Lorna NMN Division of Director after

6

24 hours a Funeral D letely filled

To the T

Physician/Medical py Completed Be Certification: To

edical

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Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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event, the Medical Examiner must be nothing at

natural, or

Hygiene.

Pages 1 and 2 should be filt ment of Health and Mental H lant: If from 27 Is marked out

Department of Important: If any Injury or page.

Physician

/Medical

25. Wes case referred to medical 1 ☐ Yes

27. Menner of Deeth 5 Pending investigation 1 Netural

2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

(Check only one)

29a. Certifie

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

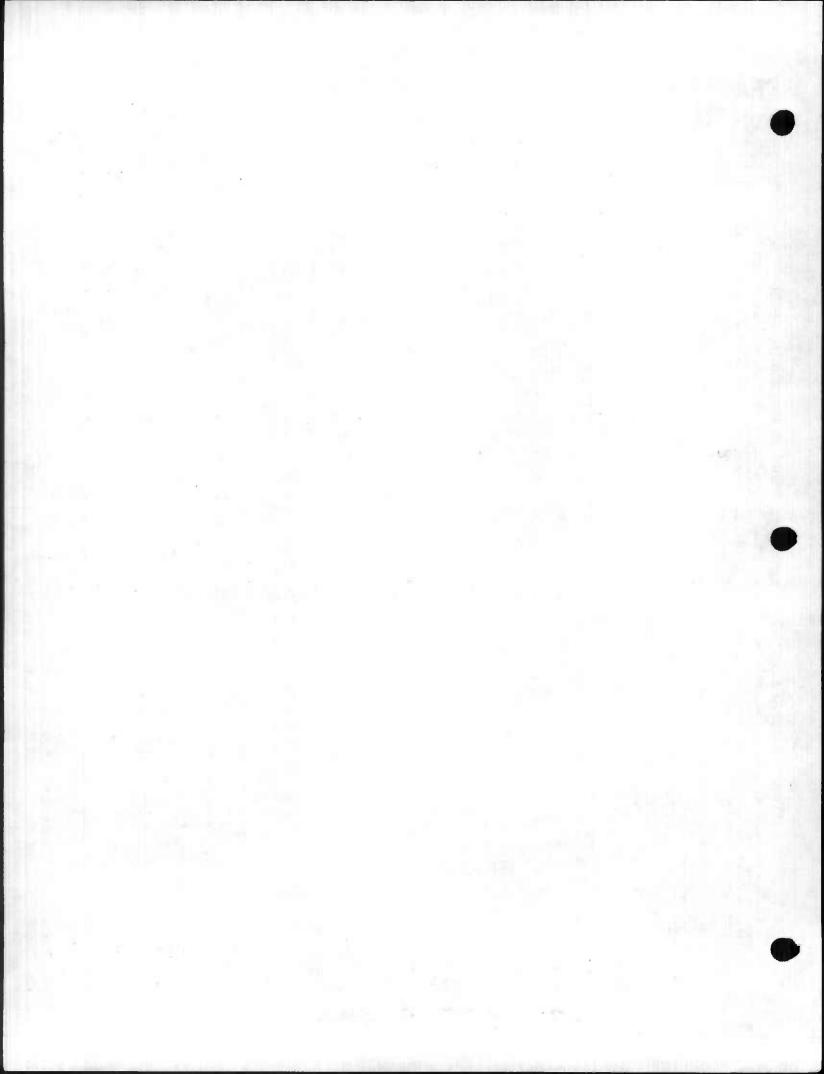
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29d. Dete signed (Month, Day, Year)

end address of person Kobert 59

filed (Month, Day, Year) FEB 2 2 1999 32. Registrer's Signeture

State



Funeral Director show

1. Decedent's Name (First, Middle Last)

2 should be filed within 72 hours after and Mental Hygiena. 3altimore, Maryland 21215-0020 parmit. Peges 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum

> Physician /Medical **Examiner**

ettending physician and for use es the bunal-transit P.O. Box 68760. Division of Vital To the Hospital or Attending P within 24 hours after deeth.
To the Funeral Director: After

DeWitt, Virgie

Physician February VIRGIE ELEANOR DeWITT /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deam 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Houra Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpleca (Stete or Foreign Country) Days Yrs 217-28-6863 88 MARCH 2, 1910 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Madical Examiner must be notified at Director MARYLAND WASHINGTON HAGERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 WALNUT STREET, APT. 301 21740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: 3 Nidowed 4 Divorced Year or Dates: WHITE Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ROMER LUTHER SHANK 2 ANNIE CAROLINE DELAUDER 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) GERALDINE M. STARLIPER/DAUGHTER 8115 MAPLEVILLE ROAD, BOONSBORO, MARYLAND 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/22/99 BOONSBORO, MARYLAND BOONSBORO CEMETERY 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Boonsboro, Maryland immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury OBSTRUCTURE PULMONIARY DISBASK CHRONIC Physician/Medical resulting In death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown HYPORPONSION DIARGED MOZLIPUS, HYPORTHYby 24b. Were autopsy findings 24a. Was an autopsy REDOISM 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 SNetural 5 Pending investigation 2 Accident 1 Yes 2 No 3 ☐ Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Medical 29a. Certifier (Check only one) 29b. Signature and title of dertiller 29c. License number 046622

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

3 Time of Death

10d. Inside City Limits

21713

21713 Approximete Interval Between Onset end Death

2 WEEKS

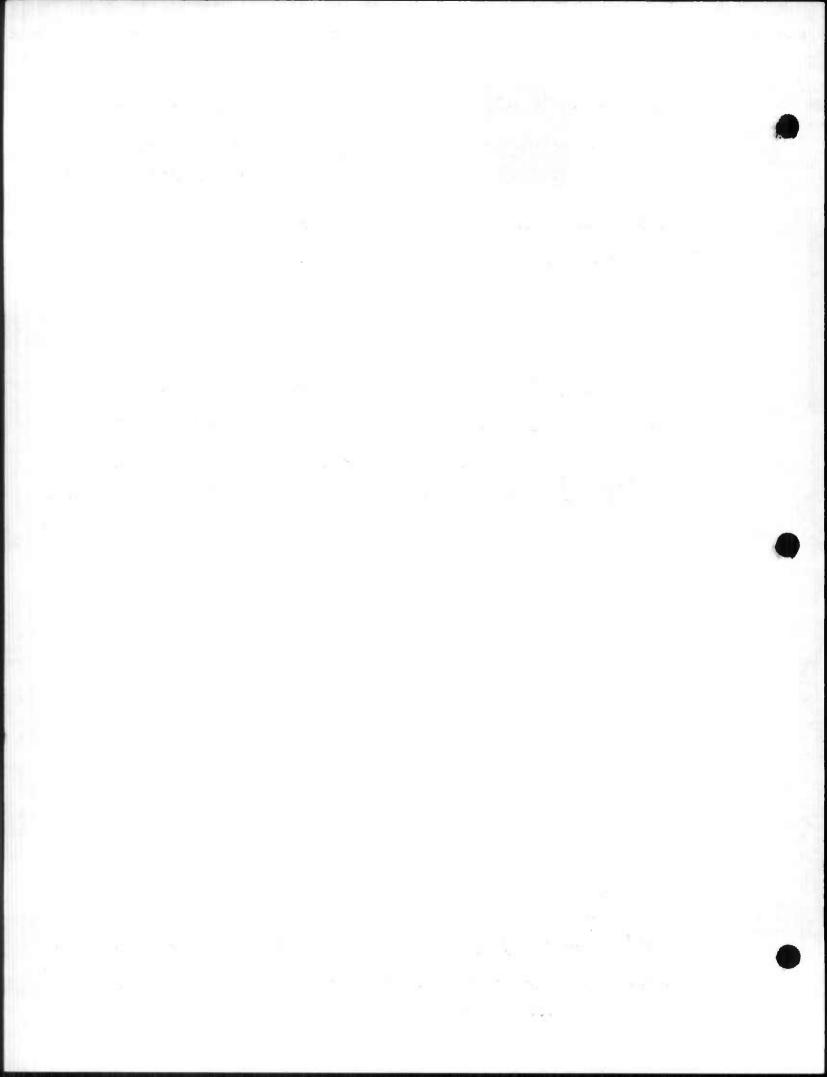
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2. Date of Death

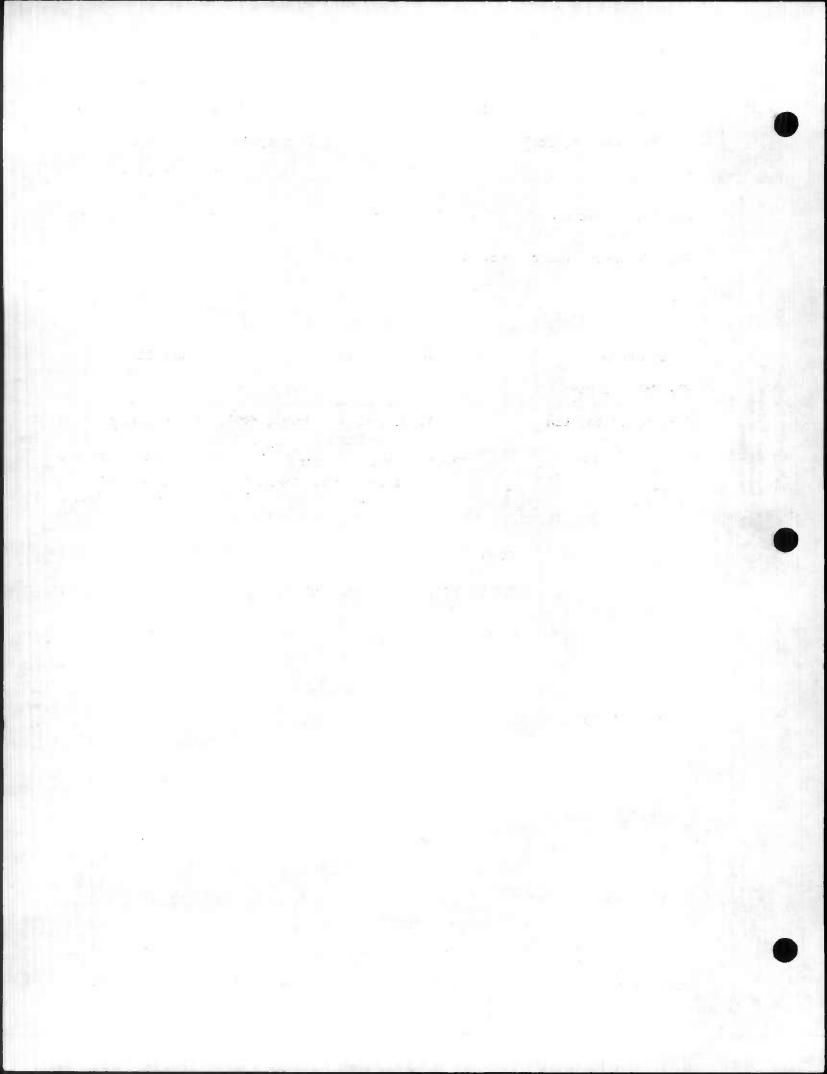
aveileble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) MEADOW VIEW DR HACKESTOWN MD 21742 31. Date filed (Month, Day, Yeer) 32. Registrer's Signature Registrar



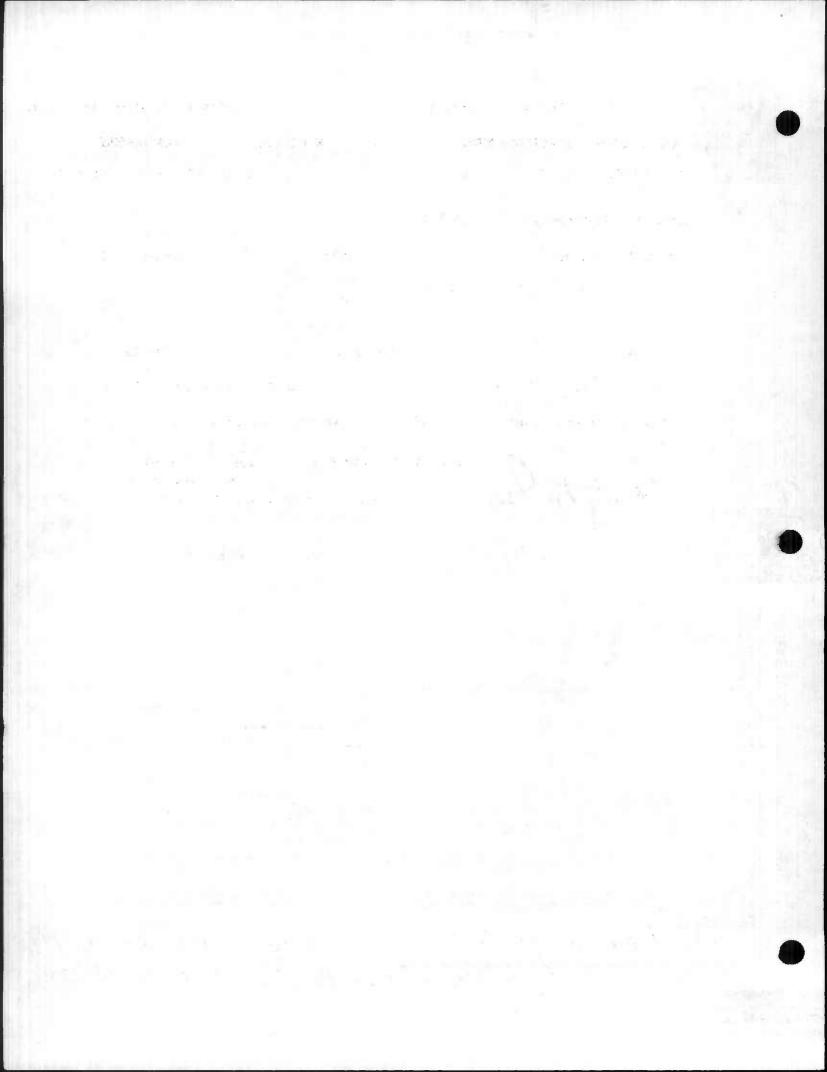
State of Maryland / Department of Health and Mental Hygiene O

	1. Decedent's Nam	e (First, Middle, La	ıst)		001	tificate of	20411	2. Date of Dec	Reg. No. ath		3. Time of Death				
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eral	5. Social Security N			7. Age (In yrs.	last birthday)	If Under 1 Year		8. Date of Birt (Month, Da)		gomery 9. Birthola	ce (State or Fore				
ctor	220-94-44	+85	1□M 2∏F	88	Yrs.	Months Days	Hours Min.		15, 1910						
	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Loc	ation				10	d. Inside City Limi				
rai Director	Maryland	Montgom	ery		lver Sp						1√∏Yes 2□1				
Funeral Director	10e. Street and Nu	mber				10f. Zip Code			10g. Citizen of V	What Countr	y?				
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ner la	11. Merital Status			dent Ever In U,	S. 13. W	Vas Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	- 14. Raci	e - America k, White, et					
9	1 ☐ Never Merr	ed 2 Married	1 Yes If Yes, Give Year or Da	20No		☐ Yes 2☐No		rioan, Bic.	Specify	<i>'</i> :					
	CALS THOUSE	15. Decedent's E		105.	16a Deced	ent's Usual Occur	netion	1	16b. Kind of Bu	Whi					
i di		cify only highest gri	ade completed)		(Give I	kind of work done O NOT use retire	during most of work	ing	100. Killia di Bu	13111033/11700	istry				
E E	5th Gra		College (1-	-4or 5+)		Service			Hospit	- 1					
Be Completed	17. Father's Name)		Tood i	VET ATCE	18. Mother's Nem	e (First, Middle,							
TO B	Eli Daksh	nitskava					Hanna 1	Mazo							
L	19a. Informant's N		Type, Print)		19b. Mailin	g Address (Street	and Number or Rur		er, City or Town,	State, Zip C	Code)				
r tra	Ilya Eyde	enson, So	n		11604	Lockwoo	d Drive,	#101, S:	ilver Sp	ring,	MD 209				
8	20a. Method of Disp		eur mayer en		lace of Dispos	ition (Name of atory or other ple	ncel 0 /10 /1	Date	20c. Location -	City or Tow	n, State				
5		☐ Cremation 3 ☐ 5 ☐ Qilhes, (Specif		state		non Cem	2/19/	1999	Adelphi	, Mar	yland				
<u> </u>		1		//			-	AT TELENTER	DAT HOME	TNC					
8 8	K	STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 200													
2	23a. Part1. Enter t														
ian	shock, or hee	It teilure. List only	one cause on ea	ich line.							nterval Between Onset and Death				
ical	Immediate Cause		DMEID	(ONT A							TIPELLO				
ner	disease or condition resulting in death)	n	a. PNEUM		r as a consequ	ionno offi				2	WEEKS				
9			CUDON		50 VE 1003	18	DIGEAGE			i i	YEARS				
the bure-transit	Sequentially list co	nditions	b. CHRON		as a consequ	/E LUNG	DISEASE			1	ILARS				
E X	Sequentially list co if sny, leading to in cause. Enter Under	nmediate orlying													
edicai	Cause (Disease or that initiated events resulting in death)	injury	C	Due to (or	as a consequ	ence of):									
2	resulting in dealth)	Last								1					
Physician/Me			d							1					
9 5	Part II. Other signif	icant conditions of	contributing to dec	ath but not resu	ulting in the un	derlying cause gi	ven in Part I.	23b. Did 1	tobacco use cor	ntribute to	the cause of de				
tach								10	Yes 2√ No	3 Probe	ably 4 Unkr				
2	HYPERI	TENSION,	ANEMIA												
enouid leted									an autopsy	evai	e autopsy findin lable prior to				
Completed											pletion of cause eeth?				
g E								101	Yes 25 No	10	Yes 2□ No				
0	25. Was case refer	red to medical					26. Place of Deat	h (Check only o	one)						
Se Co	examiner?	No	Hospital: 1 XIn	patient 2	ER/Outpatient	3 DOA OI	her: 4 Nursing Ho	ome 5□Resid	dence 6 Oth	er (Specify)					
director To Be	10100 22	h 5 ☐ Pending	28a. Date of	f Injury n, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe I	now injury occurr	red					
To Be	27. Manner of Deat		n				Yes 2□No								
To Be	27. Manner of Death 1 Natural 2 Accident	investigation	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, tactory, office								Route Number,				
the funeral director cation: To Be	27. Manner of Death 1 Natural 2 Accident	investigation	288. Place	4 Homicide building, efc. (Specify)											
the funeral director cation: To Be	27. Manner of Death 132 Netural 2 Accident 3 Suicide	investigation	288. Place	g, etc. (Specify	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat										
the funeral director cation: To Be	27. Manner of Deati 1 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only	investigation 6 Could not be determined	buildin lysician: To the to	g, etc. (Specify best of my knows sis of exeminat											
the funeral director cation: To Be	27. Manner of Deat 1 1 Netural 2	investigation 6 Could not be determined **Cortifying Ph. 2 Medical Exercises	buildin	g, etc. (Specify best of my knows sis of exeminat			opinion, death occur	red at the time,		and due to t	the cause(s)				
pletary filled in by the funarel director edical Certification: To Be	27. Manner of Deat 1 Detural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	investigation 6 Could not be determined **Cortifying Ph. 2 Medical Exercises	buildin lysician: To the to	g, etc. (Specify best of my knows sis of exeminat		29c. Licen:	opinion, death occur se number	red at the time,	date and place, a	and due to t	ay, Year)				
the funeral director cation: To Be	27. Manner of Death 1 Description 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	investigation 6 Could not be determined Could not be determined Countrying Ph 2 Medical Exer	lysician: To the baland mann	g, etc. (Specify pest of my know sis of exeminate er stated.	ion and/or inv	29c. Licens D4718	opinion, death occur se number	red at the time,	date and place,	and due to t	the cause(s) ay, Year)				
the funeral director cation: To Be	27. Manner of Deatt 13D Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and address	investigation 6 Could not be determined Cartifying Phase Country Cou	systician: To the baland mann	g, etc. (Specify pest of my knows is of exeminater states).	23a) (Type, F	29c. Licens D4718	opinion, death occur se number	red at the time,	date and place, and place, and place, and place signed by the signed by	and due to t	ay, Year)				



State of Maryland / Department of Health and Mental Hygiene 9 97186

				Ce	ertificate of	Death		Reg. No.	0	1100	
		1. Decedent's Name (First, Midd	dle, Last)				2. Date of De	ath		3. Time of	Death
Physic /Med		WILLIAM	DUNBAR	DARCEY			FEBRUA	RY 22, 1	999	1:10	P.M.
Exami		4a. Facility Name (If not institution	on, give street and number			4b. City, Town	n, or Location of Deat				
		COLLINGSWOOD	NURSING CENT	TER		ROCKVI	ILLE	MONTO	OMER	Y	
Funeral	Г	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday		If Under 24	4 Hrs. 8. Date of Bir			place (State or	r Foreign
Director		218-20-0052 Usual Residence of Decedent	1 M 2 □ F	76 Yrs.	Months Days	Hours	Min. (Month, Da April	12, 1922	Ma.	ryland	
death with the Muryland rns 23e or 28e-f show rmat be notified at	1.	10a. State 10b. Count	у	10c. City, Town or L	ocation				1	0d. Inside Cit	y Limits
Mu.	oto	Maryland Montg	omery	Gaithers	burg					1 X Yes	2□No
ier desth with the Murylar fearte 23a or 25a-f show the must be notified at	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhet Cour	ntry?	
23 w		207 Cedar Aven	ue		2087	7	16.7	United	Sta	tes	
	Funeral	11. Marital Status	12. Was Decaden Armed Forces	t Ever In U,S. 13.	Was Decedent of I	Hispanic Originan, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Rac	a - Americ k, White,	an Indian,	
21215-0020 d within 72 hours after giene. or than "naturel", or its the Medical Examine	by	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☑ Divorce	rried 1 Yes 2	No 7/14/44-	1 ☐ Yes 2 【XNo		, 50.10 (11041), 010.7	Specify	r:	hite	
5-C	Completed	15. Decede	nt's Education est grade completed)	16a. Dece	dent's Usual Occup	pation	of working	16b. Kind of Bu	siness/In	dustry	
Men Par	lg i	Elementary/Secondary (0-12)	College (1-4or	life	DO NOT use retire	d)	, working				
CA week	S	8		C	ontractor				ting		
De state de contra de cont	Be	17. Father's Name (First, Middle				18. Mother's	s Name (First, Middle,		'		
North Marks	2	John Armste	7			Anr			Mil1		-
Maryland od 2 should be file alth and Mental Hy 27 is marked othe r traumatic event		19a. Informant's Name/Relation Thelma A. Darce			ing Address (Street Cedar Ave		or Rural Route Number Gaithersb			Code) 877	
- 200		20a. Method of Disposition	y, Cousin	20b. Place of Disp	osition (Name of	i	Date	urg, MD			
Altimore mit. Pages 14 autment of He ortant: If Item injury or othe		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (\$			matory or other pla		Feb. 25,	Rockvi			and
Ball Depart mpoort my in		.21. Signature of Funeral Service	rbicensee /	2	2. Name and Addre	ess of Facility		uneral			
20119		1 Hary	m. Time	1	0 East De	eer Par	k Dr., Ga			MD 20	877
		23a. Parti. Enter the duringe, o shock, or heart faire. Lis	r complications that cause							Approximate Interval Betw	1
Physician		0							-	Onset and D	eath
/Medical		Immediate Cause (Final disease or condition	Unn	en adat	nointes	Lind	blee	1		minut	23
Examiner		resulting in death)	a. Diff	Due to (gr/as a conse	quence of):	1111011	RICO	4		7111111	
70 45	ne			V							
ecute ind trans	Examiner	Sequentially list conditions, if any, leading to immediate	0.	Due to (or as a conse	quenca of):						
50, e exe ian a	m	rf any, leading to immediate cause. Enter Underlying Cause (Disease or Injury							i		
68760, filicate be ex	lica	that initiated events resulting in death) Last	C	Due to (or as a consec	quence of):						
	/Medical		d						-		
S, P.O. BOX se that the death cer gned by the attendin be detached for use	Physician	Pert II. Other significant conditi	one contribution to death h	nut not requising to the		un la Bant l	non Plat	10h	1		
t the d	hys	Total Suid agrinoan conditi	ona contributing to death t	out not resulting in the u	indenying cause gi	ven in Part I.	1 🗆	lobacco use cor Yes 2□ No	3 Prol		Jnknown
ds, P	by P						''	TUS ZLINO	3 10	Jably 410	MIKHOWII
lecords law requires as been sign								an autopsy	24b. We	ere autopsy fir	ndings
w require	Completed						perfo	med?	CO	ailable prior to mpletion of ca death?	
Record The law require ste has been si page 2 should	E C						400	· · · ·		1	6
_ F # G		25. Was case referred to medica					1 1 1	/ \	11	Yes 2	40
	o Be	examiner?	Hospital:	• • • • • • • • • • • • • • • • • • •	Ott	or t	Death (Check only o				
Phys rthis	-	27. Manner of Death	1 ☐ Inpati				ing Home 5 ☐ Resident	now Injury occurr		y)	
Division or Attending after death. Director: After	tlor	1 Natural 5 Pendin	ng (Month, Da	y Year) Injury	Wo	rk? Yes 2 ☐ No		ion injury occur			
Vite f	fica	3 Suicide 6 Could	not be	jury - At home, farm, sti				Street and Numb	er or Rura	I Route Numb	201
Div A affer affer din by	Certification:	4 ☐ Homicide determ	building, el	c. (Specify)	ioot, ractory, office		City or Tov		07 07 71012	r iodio rigino	·01,
apita nours neral		29a. Certifier Certifyir	ng Physician: To the best	of my knowledge, deati	h occurred at the tie	me, dete end p	pleca, and due to the	cause(s) end me	nner es si	ated.	
Division or To the Heaptlai or Attending Phwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	edicai	(Check only 2 Medical one)	Examiner: On the basis of and manner st	t examination end/or in	vestigation, in my o	ppinion, death	occurred et the time,	date and place, a	and due to	the ceuse(s)	
Vithi To th	Σ	29b. Signature and title of certifie	10-1	mas O	29c. Licens	se number	0	29d. Date signed	(Month,	Day, Year)	00101
15+1		Patriora &	(. 10ms fet	July 1	D_{s}	5191	6' I	ebrud	ny a	22, 19	199
, , ,		80. Name and address of person	who completed cause of c	death (Item 23a) (Type,	Pgint)	n./ =	Halla n	1 . 11	h.	10	-0.0
		Patricia L. Tou	usko, MD, 1	1140 Roc	Kville 1	1Ke7	1348, Ko	CKVI1/E	2, 111	V 200	852
Sta		31. Date filed (Month, Day, Year)	32. Degistr	rar's Signature	1 .	,	1		-		
Regist	ar	FEB 24 1	1999	Ø.	ppours						



State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Yaar **Physician JAPHUS** DINO DAWKINS FEBRUARY 21, 1999 5:15 am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK, MD MONTGOMERY | Months | Days | Hours | Min. | 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 MM 2□ F Yrs. 249-13-8251 39 Director Oct. 14, 1959 SC Usual Rasidence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. tnside City Limits show 1 X Yas 2 No Director MD Prince George Hyattsville 288-4 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? à Nerns 23a 2208 Calvert Street 20783 Funeral United States 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, White, atc. 72 hours after 1 ☐ Yas 2 No 1 ☑ Nevar Married 2 ☐ Married ð Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: **Black** à 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 10th Unemployed -Disabled parmit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Iham 27 is marked other
any Injury or other traumented other 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) B Japhus Dawkins Jackie Stevens 19a. tnformant's Name/Relationship (Type, Print) 19b. Maiting Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 4707 Banner Street, Hyattsville, MD 20783 Neshell Stevens - Sister 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Data 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Forest Hills Cemetery 3/1/99 Clinton, MD 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility R. N. Horton Co. Morticians, Inc. X.72) 450000 600 Kennedy Street, N.W., Wash., DC 20011 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician /Medical immedieta Causa (Finat disaasa or condition resulting in deeth) PNEUMONIA Examiner Dua to (or as a consequence ot) Examiner lician and burial-transit NOCARDIA Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): · ACQUIRED IMMUNODEFICIENCY SYNDROME Box 68760. Physician/Medical the Dua to (or as a consequance of): Part II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 No 3 Probably 4 Unknown Non-insulin dependent diabetes mellitus Completed by Records. The lew requires 24b. Ware autopsy findings aveitable prior to completion of cause of death? 24a. Was en autopsy performed? Hepatitis C virus 1 Yas 2 No 1 Yas 2 No Division of Vital Attending Physician: Be 25. Was casa rafarred to medicel examinar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending invastigation 1 Natural n 24 hours after deeth.

The Funeral Director: After bletchy filled in by the fun 1 Yas 2 No 2 Accident 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide ò 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edical 29a. Cartifian To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signatura and titla of certifian 21st February, 1999 D0052931 Varied. 30. Name and address of person who completed ceusa of death (from 23a) (Type, Print) 11119 Rockville pike #100 ROCKVILLE MD 20852 WARAS AL JAWAD

DHMH 16 Rev 6/95

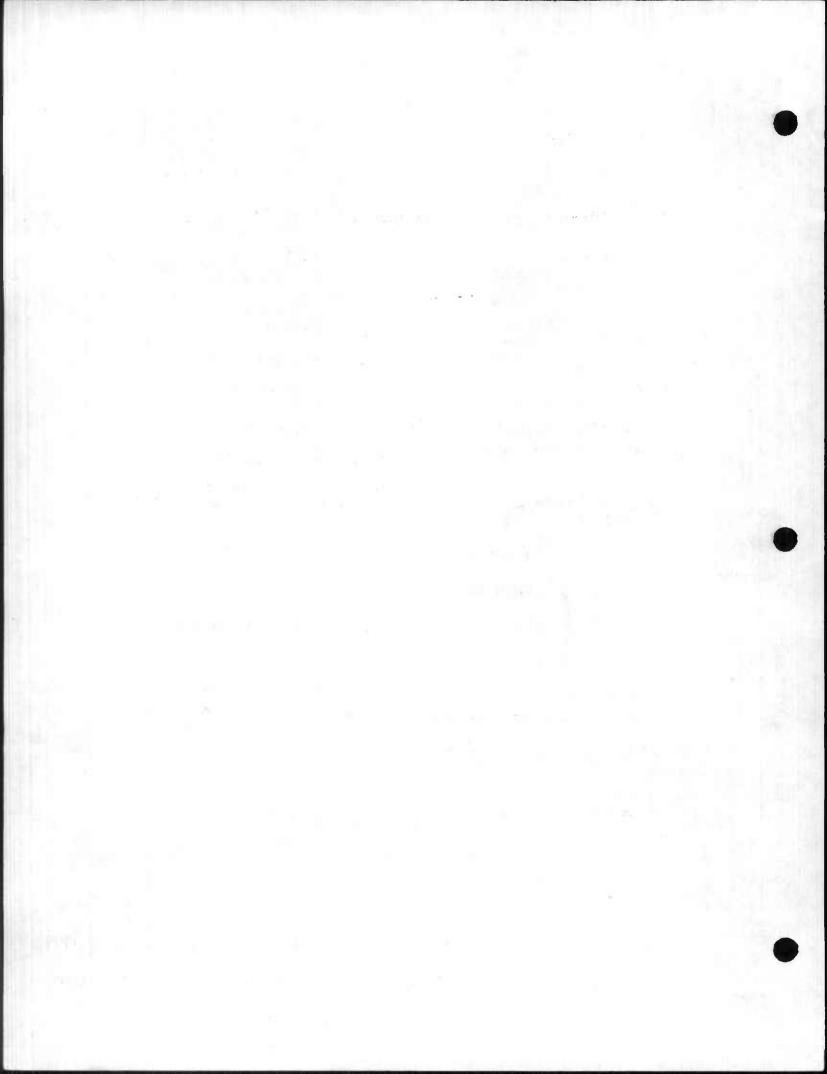
State

Registrar

31. Data filed (Month, Day, Year)

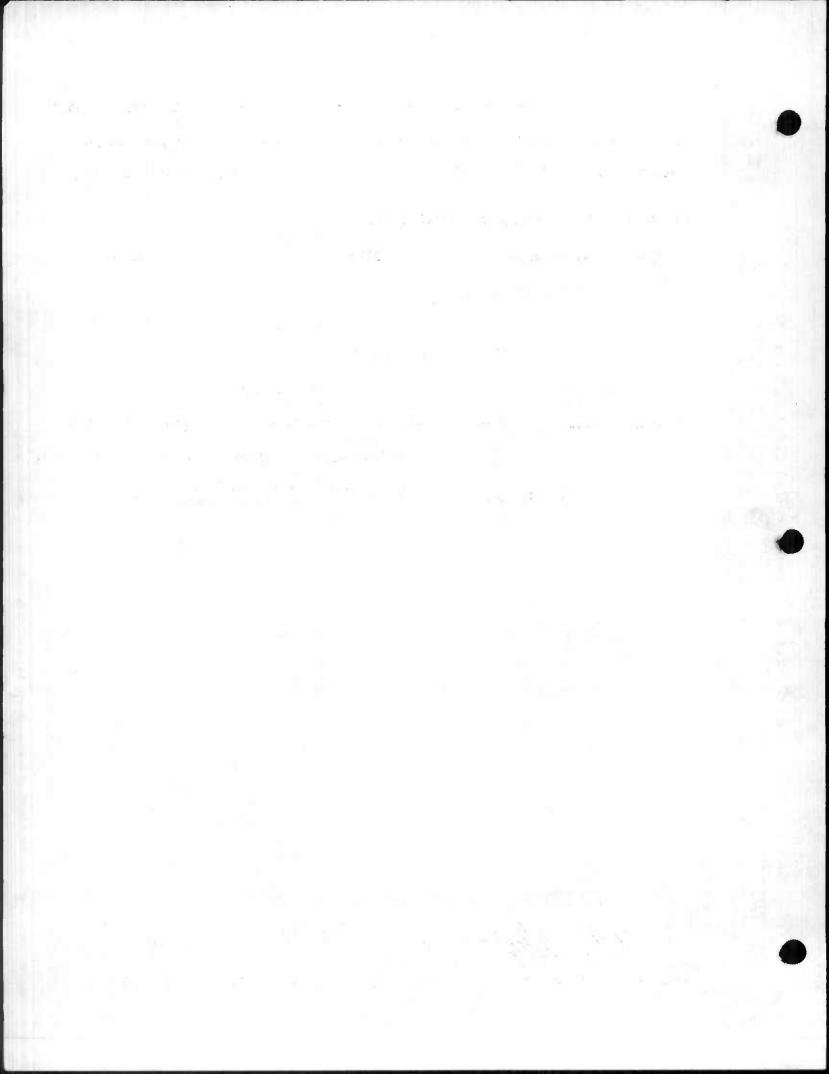
FEB 25 1999

32 Registrar's Signatura



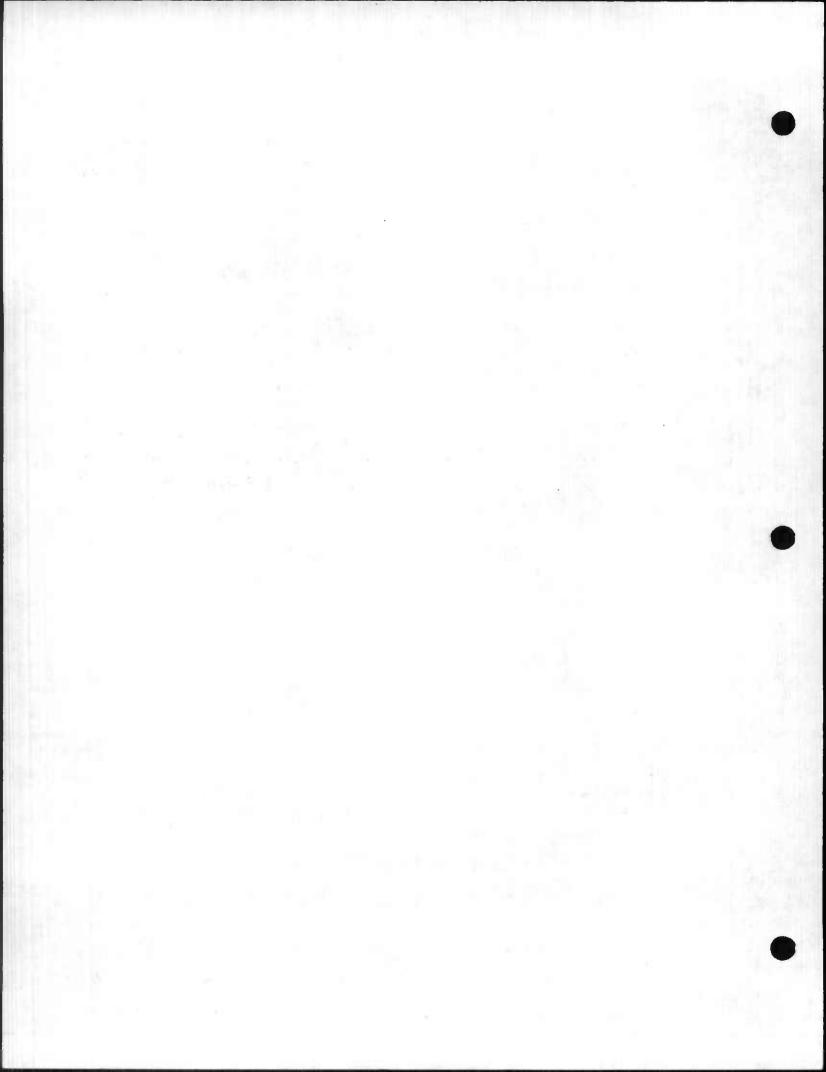
State of Maryland / Department of Health and Mental Hygiene Q Q

					Certifica	ate of	Death		Reg. No.	3 (11100
Physic	ian	Decedent's Name (First, Middle, L.						2. Dete of De Month	Day	Yeer	3. Time of Death
/Medi				Everts	on Dix			Februa	ry 23,		4:35 AM
Exami	ner	4e. Fecility Name (If not institution, g.					4b. City, Town,	or Location of Deet	h 4c. Coun	ty of Deeth	
	м	Collington Episco					Mitchel:			e Geo	orge's
Funeral Director		068-24-3849	1 DIM OF F	(In yrs. last bir 86	Yrs. If Uni	der 1 Yea ns Deys		in. (Month, De	th by, Year) 0, 1912	9. Birthi Cou I 1 1	plece (State or Foreign intry) inois
and *		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City. Tow	n or Location						10d. Inside City Limits
Maryl sho	ō	Maryland Prince	e George's		ellvil	1.					1 ☐ Yes 2 No
the 28a-	Director	10e. Street and Number	George 5	HILCH		Zip Code			10s Citizen of	Milhat Carr	
with with			1 7 1						10g. CitIzen of		
Seath rrs 2%	era	10450 Lottsfor	12. Wes Decedent Ev	ver in U.S.		721	Hispanic Orlain?	(Specify Ves or No	United	Stat	
d within 72 hours effer death with the Maryland giene. sr than "natural", or flems 23s or 28a-f show in Madical Examiner must be notified at	by Funeral	1 Never Merried 2 Married 3 Widowed 4 Divorcad	Armed Forces? 1 X Yes 2 □ No	A. /		pecify Cul		(Specify Yes or No erto Ricen, etc.)	Speci	eck, White,	
2 ho	ted	15. Decedent's E	ducation	16e.	Decedent's U	suel Occu	petion		16b, Kind of E	-	
- 3	Completed	(Specify only highest gi Elementery/Secondery (0-12)	rede completed) College (1-4or 5+)	1	(Give kind of life. DO NOT	work done Luse retin	ipetion a during most of v ed)	vorking			
gien gien	Con	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5+		ct Deal	er			Art D	ealer	
al Hy	Be (17. Fether's Neme (First, Middle, Las	0				18. Mother's N	lame (First, Middle	Meiden Sume	me)	
nd 2 should be file lith and Mental Hy 27 is marked other traumatic event	Tol	George E. Dix					Janet	Dortch			
sho and s m		19e. Informent's Neme/Relationship	(Type, Print)	19b	. Meiling Addre	ess (Stree	et end Number or	Rurel Route Numb	er, City or Town	, Stete, Zip	Code)
end alth		Charles F. Keyes	(nephew)		420 32	nd S	treet, N	W, Wash:	ington,	DC	20015
H to		20e. Method of Disposition		20b. Place of cameter	Disposition (A	Verne of	ace)	Date	20c. Location		
permit. Pages 1 and 2 should be filed within Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, The Monce.		1 Burial 2 □ Cremetion 3 [4 □ Donetion 5 □ Other (Speci	□Removal from State ify)		ian Cem			2-26-99	Staten	Islar	nd, New Yo
permit. Depertuimports any inju		21. Signeture of Funerel Service Lica	nsee		22. Neme	end Addr	ess of Fecility				
8858		Illen W.	Ross		Rapp	Fune:	ral Serv	ices, P.	Α.	m 00	010
		23a. Pert1. Enter the disease, or con shock, or heert feilure. List only	nplications that caused th	ne death. Do r	not enter the m	ode of dv	ing, such es cerd	Silver Spiac or respiretory e	oring, I	1D 20	910 Approximete
Physician		shock, or heert feilure. List only	one ceuse on each line.								Intervel Between Onset and Death
/Medical		Immediate Cause (Finel									
Examiner		disease or condition resulting in death)	e. Chronic							14	4 months
	ē				consequence o	ŕ				ì	
uted	Examiner	Conventially list and distant	b. Metastat		onsequenca o		er			10	6 months
exec nn en ial-tr	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	Di	ue to (or es e c	onsequenca o	or):				1	
eath certificate be executed ettending physicien end for use es the burial-transit	edical	fired fulfieled events	C	ie to for as o o	onsequence of	۸.				-	
g phy es th	중	resulting In death) Lest	50	ie to (oi as e c	orisequerice o	1).					
ndin use	M/U		d								
es that the death ce igned by the ettend be deteched for us	Physician/	Pert II. Other significant conditions	contribution to dooth but	nat requiting in	the under in		in a la Dani I	005 DI4			
by the	hys	Total algunicant conditions	contributing to death but i	not resulting in	i the underlying	g cause g	ven in Part I.				o the cause of death? bebly 4 □ Unknows
that s	by P	Anemia						_ 1⊔	Yes ZIAINO	3 Pro	bably 4 Unknow
lew requires that the death certificete be executed es been signed by the ettending physicien end 2 should be deteched for use es the bunal-transit								24e. Wes	en eutopsy	24b. W	ere autopsy findings
v require been sig	Completed								rmed?	av	aileble prior to impletion of ceuse
9 - 6	E C							11 8.00	y		deeth?
icate		- W						10	res 2 No	1	☐ Yes 2 No
Physician: The this certificate fral director, per	Be	25. Was case referred to medicel examiner?	Hospital:			0		eath (Check only o			
Phys this ral di	T.	1 Yes 2 No 27. Menner of Deeth	1 L Inpatient		tpetient 3 0	DOA Iniu	4 Nursing	Home 5□ Resid			y)
ding h. After fune	tou	1 Neturel 5 Pending	28e. Dete of Injury (Month, Dey Y	(eer) 28b. T	njury M	28c. Inju Wo	rk?]Yes 2∐No	28d. Describe	low injury occu	red	
or Attending efter death. Director: After d in by the fune	Certification:	3 ☐ Sulcide 6 ☐ Could not b	9 00 01 11	At home for			148 5 140	Opf Leasties (Daniel and Min		10-1-11
	E E	4 ☐ Homicide determined	28e. Pleca of Injury building, etc. (Specify)	m, street, tecto	ory, omce		City or To	vn, Stete)	<i>per</i> or Hure	el Route Number,
pital orai filled	0	29a. Certifier 1X Cartifying Pt	volales. To the book of		4 - 4						
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20	-	· VIVI	MINE)	,,,		-	10 EVE - EVE		0/00/	77	
		30. Name and address of person who				n .			- W		
		William F. DuBoyo			tering	Driv	e, Upp	er Marlbo	ro, MD	20774	+
Sta Registr		31. Date filed (Month, Dey, Year)	32. Registrer's		4 1	park	11				
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State of Maryland / Department of Health and Mental Hygieneg 9 07 | 89

	Decedent's Name (First, Middle, L.	act)		Ce	runou	te oi	Death	2. Date of D	Reg. No.		3. Time of Death	
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dical	Harold G	-		ougla	S		45 Oh Taus	Februa	-		12:55 PM	
iner	4a Facility Name (If not institution, gi		,				4b. City, Town, o			nty of Death		
	3502 Murdock Ro 5. Social Security Number 6.	-	no the con t	and fainth days	If Lind	er 1 Year	Kensin			tgome:		
r	218-37-4073	Sex 1⊠M 2□F	76	ast birthday) Yrs.	Months				, 1922	Jama:	place (Stete or Foreign Mry) West ica, Indie	
	Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation					1	0d. tnside City Limits	
tor	MD Montgo	mery	K	ensin	gton						1 ☐ Yes 2 ☒ No	
Director	10e. Street and Number				10f. Z	ip Code	THE TELL		10g. Citizan o	What Cour	ntry?	
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by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?	S. 13.	Was Dec if Yes, sp 1 ☐ Yes		Hispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	lo- 14. R B	ace - Americ leck, White, city: BI		
Completed	15. Decedent's E (Specify only highest gi	Education		16a. Dece	dent's Us	ual Occup	pation during most of w	orkina	16b. Kind of	Businass/Ind	dustry	
nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	use retire	od)	UKANY				
00	12			Dr	iver	for	Embassy					
Be	17. Father's Name (First, Middle, Las	1)						ame (First, Middl		ama)		
To	James Douglas							Reynolds				
	19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata,											
	Myrtle Douglas	(wife							T	20895		
	20a. Method of Disposition 1 □			ace of Disponentery, cre			emetery	Date 1 2 / 26 / 9 9	20c. Location		ing, MD	
ans	21. Signature of Funeral Service Lice		Gat								C	
	1 Steven 1 St	rend		S	ilve	Spr	ess of Facility F: 500 Un	20901		West	ICICI	
	23a. Pert1. Enter the disease, or cor shock, or heart failure. List only	nplications thet cause y one cause on each	d the death line.	. Do not en	ter the mo	de of dyi	ng, such es cardi	ac or respiratory	arrest,		Approximate Interval Between Onset end Death	
	Immediate Cause (Final disease or condition	Chron	ic ga	stroint	lestin	al	bleeding	q		1	10 years	
	Immediate Cause (Final disease or condition rasulting In death) a. Chronic gostointestinal bleeding Due to (or as a consequence of):											
Examiner	Arteriorenous rathermations of gastrointestinal track									k i	10 years	
Eal	Sequentially list conditions,	0.		es a conse			1				J	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									1		
0	that initiated events resulting In death) Lest	G	Due to (or	as a consec	quence of):					TEN	
		d										
Physician/N	Part II. Other significant conditions	contributing to death I	out not nesu	iting in the s	ınderlvina	cause di	ven in Pert t	23h Die	d tobacco use o	contribute to	the cause of death!	
	Dementia			and a constant		outor g.		23b. Did tobacco use 1 ☐ Yes 2 ☐ N			bably 4 Unknow	
od by		1	· d	1.				24a. Wa	s en autopsy	24b. W	ere eutopsy tindings	
Completed by P	Cerebrovascu	uar au	Laten	<i>T</i>				per	formed?	co	allabla prior to mpletion of cause death?	
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Com								eath (Check only	ona)			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Yeer
FEBRUARY 23 1999
4b. City, Town, or Location of Death
4c. County of Death **Physician** Mamie Rebecca Everly 23 1999 /Medical 4e Facility Neme (If not institution, give street and number) Examiner Washington County Hospital Hagerstown Washington Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 2X) F Director 213-24-9857 81 Oct.3,1917 Virginia Usuel Residence of Decedent 10a State 10h. Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Madical Exampler must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Washington Hagerstown 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code USA 16110 Everly Road Funeral 21740 death 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Yes 2 No 1 Never Merried 2 Merried 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: p lf Yes, Give Year or Dates: 3 Widowed 4 Divorced White Completed 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ified within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed with Department of Heelih and Mental Hyglen Important; if tem 27 is marked other that any Injury or other traumatic avant, that page. 8 Housewife Home 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Freeman Carroll Boyce Valley Virginia Belle Holiday 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Charles J. Everly/Husband 16110 Everly Road Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Park 2-27-99 Hagerstown, Maryland 22. Name and Address of Fecility
Osborne Funeral Home 21. Signeture of Funerel Service Licenses 425 S. Conococheague St.Williamsport,MD 21795 Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heard failure. List only one cause on each line. Approximeta Intervat Between Onset and Deeth **Physician** /Medical immedieta Cause (Final tours diseese or condition resulting in daeth) Examiner Due to (or as a consequence of): mellitu abela the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical Due to (or as a consequence of) 88 Por P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d be detact 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings evailable prior to should Completed 24a. Wes an eutopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred edical Certification: 28b. Time of 1 Natural 2 Accident 5 Pending invastigation 1 ☐ Yes 2 ☐ No 6 Could not be detarmined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and menner as stated.

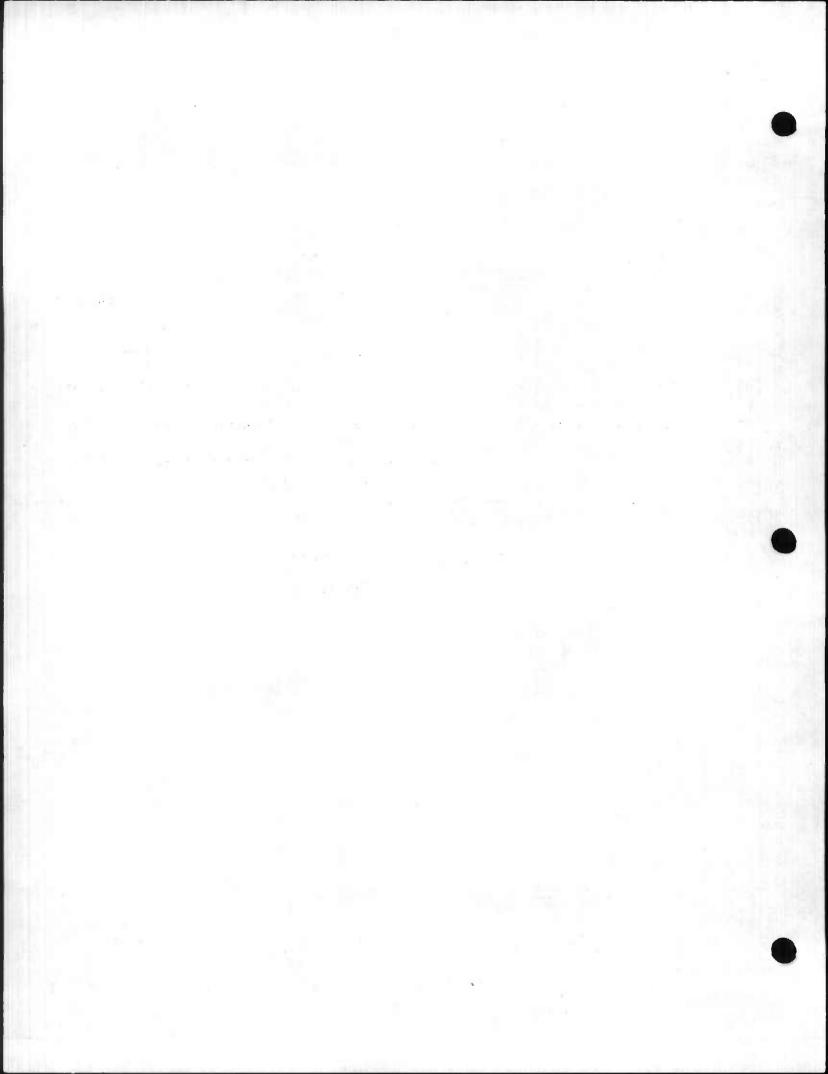
| Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier D2145 140-1 30, Nema and address of person who completed cause of death (Item 23a) (Type, Print) HBOUL WATERD MM 12821-OAKITIC AVE. HAGERSTUN MOZITYZ 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

FEB 2 4 1999

MAMILE



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 9 9 0 7 1 9 2

			(Certifica	ate of	Death		Reg. No.	U	1196
	1. Decedent's Name (First, Middle, Las	it)					2. Date of De Month	ath Day	Year	3. Time of Death
Physician /Medical	Brantford G. El	lliott					Februa	ry 20, 1	999	9:10 AM
Examiner	4a Facility Name (If not institution, give	street and number)				4b. City, Town, o	r Location of Deat	4c. County	of Death	
	11509 Stonewood I	Lane				Rockvi1	1e	Montg	omer	y
Funeral Director	112 10 0200	ex 7. Age ☐M 2☐F	(In yrs. last birth	Month	ler 1 Year s Days			th y. Year) 3, 1917	Count	ace (Stete or Foreign try) 165566
P .	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Looption					4,	Od Annida City I imite
arytar ahow alat									16	Od. Inside City Limits 1 ☐ Yas 2 ☒ No
or 28s-4 se notified	Maryland Montgome	ery	Rockvil		W- O- 1-			40-02	2	
	10e. Street and Number				Zip Code			10g. Citizen of W		
e 23e mest.	11509 Stonewood La		main II o		0852	Historia Origina	Casalti Van as Na	United	State - America	
Maryland 21215-0020 if 2 should be field within 72 hours after death vith and Mental Hygiene. 7 is merked other than "natural", or items 23 trauming event, the Medical Examinar must. To Be Completed by Funeral	11. Marital Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			ecify Cub 2 □XNo		Specify Yas or No irto Rican, etc.)	Specify:	k, White, e	etc.
21215-0 ed within 72 ho ygiene. A than 'naturn f, the Medical.	15. Decedent's Ed (Specify only highest grad		16a. D	ecedent's Us	sual Occup	pation during most of w	odvina	16b. Kind of Bu	siness/Ind	ustry
nple un ple	Elementery/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT	use retire	d)	orking			
Con Hatte		4	E	nginee	r			Manufac		ng Firm
Be septime	17. Fathar's Name (First, Middle, Last)						ame (First, Middle		в)	
yla Men Men Men Men Men Men Men Men Men Men	William Henry Ell:	lott				Elizab	eth Walk	er		
2 sh and lam	19a. Informant's Name/Reletionship (7						Rural Route Numb			Code)
	Barbara Ann Moskov	vitz (daugh				Avenue,	1		_	20817
Saltimore, emil. Pages 1 s Separtment of Has mportant: if Nem ny Injury or othe tics.	20a. Method of Disposition 1 Darial 2 Cremation 3 D	Removal from State	20b. Place of D cemetery,	Disposition (A cremetory o	iame of r othar pie	ice)	Date	20c. Location - 6	City or Tox	wn, State
Pages nent of ant. If the ury or o	4 □ Donation 5 □ Other (Specify		Chesap	eake C	rema	tory	2-22-99	Beltsvi	11e,	Maryland
B Part B	21. Signature of Funeral Service Licens	see				ess of Facility				
0 88888	X 0-200	Ma0.	200				vices, P Silver			land 20910
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)		atic Property at the state of t			cer		3	3	3 years
68/6U, ifficate be executed gphysician end as the bunal-transit ledical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in death) Last	C	ue to (or as a co					374		
oertific ding pass as		d								
IS, F.O. BOX es that the deeth cert igned by the attendin be deteched for use by Physician/N							1			
the d	Part II. Other significant conditions co	intributing to death but	not resulting in t	he underlying) cause gi	ven in Pert I.	1			the cause of death?
T the debt of T	24-4						1	Yes 2 No	3∐ Prob	ably 4 🖾 Unknown
sw requires to the special spe							24a. Was	an autopsy rmed?	ava	ore autopsy findings illable prior to appletion of cause death?
The le							10	Yes 2∏ No	10	Yes 2□ No
sician: The sicians of Be Co	25. Was case referred to medical examiner?					26. Place of D	eath (Check only	one)		
T dis y	1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient	2 ER/Outp	atient 3 1	DOA O	her: 4 Nursing	Home 5 ☑ Resi	dence 6 Othe	or (Specify)
ading Ph adit. vr. After th he luneral	27. Manner of Deeth 1 XNatural 5 Pending 2 Accident investigation		Year) 28b. Tin		28c. Inju Wo 1	ryet ork?]Yes 2 ☐ No	28d. Describe	how injury occurre	ed	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the luneral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm (Specify)	n, street, fact	ory, office		28f. Location (City or To	Street end Numbe vn, Stete)	r or Rure	Route Number,
n 24 hound	29a. Certifier (Check only one) 1 CM Certifying Phy one)	vsician: To the best of einer: On the basis of einer state	xamination and/	death occurre or investigation	d at the ti	me, date end plac opinion, deeth occ	ce, end due to the curred et the time,	cause(s) and mai date and place, a	nner as sta ind due to	ated. the cause(s)
within within comp	29b. Signature and title of certifier	.,,		2	9c. Licens	se number		29d. Data signed	(Month, I	Dey, Year)
20	HIL	with	-		MD115	506	1	February	22.	1999
	30. Neme and address of person who c	ompleted cause of dea	ith (Item 23a) (Tr			, , ,	1.	coldary	22,	
	Frederick Pearson	Smith, M.D	., 5401		rn Av	ve., NW,	Washing	on, DC	200	15
State Registrar	31. Date filed (Menth Bey, Year) FEB 2 2 199	32. Registrar	-	9 1	/	,				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev **Physician** NELLA EPSTEIN /Medicai 20 1999 02 7:35PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Montgomery Rockville Shady Grove Adventist Hospital 5. Social Security Number 6. Sex If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplaca (Stete or Foreign Country)
 ITALY **Funeral** Deys 1 □ M 🛠 🕏 F Months Hours 14 7279 86 Director 01 09 1913 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location show r 28a-f show 10d. Inside City Limits XX Yes 2□No Director MD MONTGOMERY SILVER SPRING the ! 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t 'natural', or items 23a or 3700 INTERNAITONAL DRIVE 20906 USA Funeral filed within 72 hours after deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes AM No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Stetus 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Merried altimore, Maryland 21215-0020 Specify: WHITE 1 ☐ Yes 2 No Specify: py 3 XXVidowed 4 Divorcad Yeer or Dates: Be Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Bustness/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) BOOKKEEPER HOSPITAL ADMINISTRATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) . Pages 1 end 2 should be fill timent of Health and Mental H tant: if item 27 is marked oth jury or other traumatic even MANUEL (UNAVAILABLE) ERNESTINE (NOT AVAILABLE) 2 19e. Informent's Neme/Rejetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) STEVE EPSTEIN 2923 CURRY ST, YORKTOWN, NY (NEPHEW) 10598 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete tXBurlei 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) ZION HAR 2-23-1999 COLLINGSDALE, PA 21-Signature of Funeral Service Li 22. Name end Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPEL, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852
Approximate Interval Between Onset and Deeth 23a Part I. Enter the disease, or com-shock, or heart failure. List only nications that caus one cause on each Physician /Medical Immediate Cause (Final disease or condition resulting in death) tew hours Ischemia estinal Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or trijury that initiated events resulting in deeth) Lest Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?

þ should be Completed page 2 funeral director. Be Certification: To n 24 hours efter death.

The Funeral Director: After the pletely filled in by the funeral

signed by

been

certificate

this

Division of Vital Records.

Attending Physician:

ò Hospital 24 hours e

To the Hosp within 24 ho To the Fune completely f

1 Yee 2 10

urosepsis Serere metabolic Acidosis

3 Probably 4 ☐ Unknown 24e. Wes en eutopsy performed?

1 Yes 2 No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

Insufficiency 26. Place of Deeth (Check only one) Renal Severe 25. Wes case referred to medical exeminer? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menner of Deeth

28e. Dete of Injury (Month, Dey Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28d. Describe how tnjury occurred 28c. Injury et Work? 1 Yes 2 No

5 Pending Investigation 2 Accident 8 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide

1 Cartifying Phyalclan: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceuse(s) and menner es steted.

2 Medicat Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pieca, end due to the cause(s) end menner steted.

409, Rockielle mo 2085

29b. Signeture end title of certifier Gri ntano 29c. License number D 46598

Feb. 20, 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

G. Gupta, mo congressiona lare

31. Dete filed Month, Day, Year) State Registrar

Medical

1 Neturei

29a. Certifier

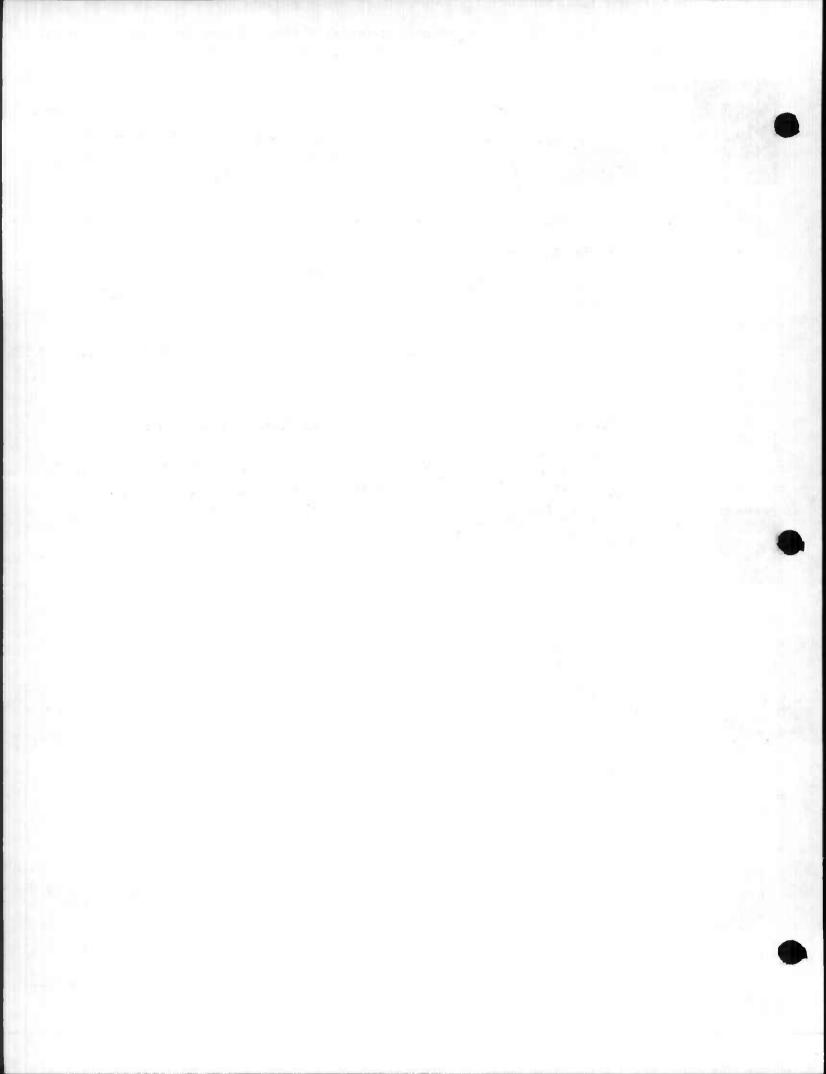
(Check only one)

32. Registrer's Signature FEB 23 1999

DHMH 16 Rav 6/95

29d. Dete signed (Month, Dey. Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

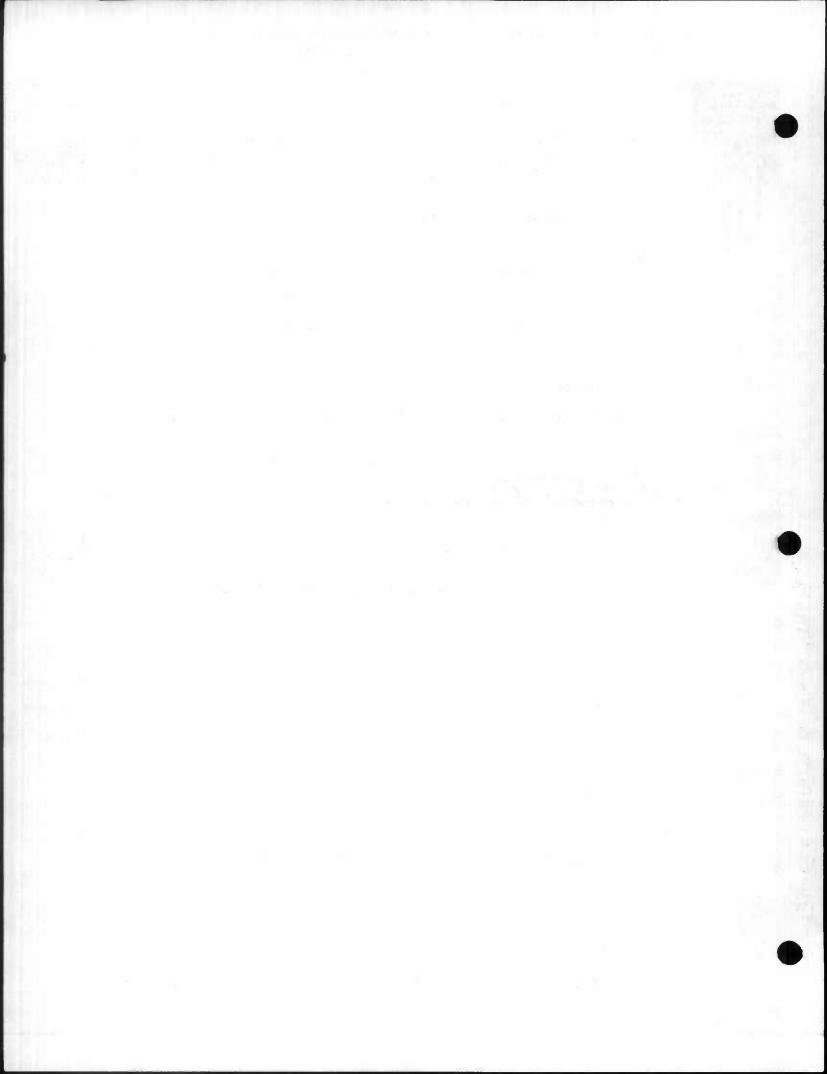


State of Maryland / Department of Health and Mental Hygiene 9 9 07 | 9 4

		1. Decedent's Name (First, Middle, L	ast)				of Death		a of Death			3. Time of Death
Physicia /Medica		JAMES	HOWARD		EWELL			Fe	b.	21 ^y	1999	10:50 A
Examine		4a. Facility Name (If not institution, g		er)			4b. City, Town		of Death	4c. County	of Death	
		SUBURBAN HOSPI 5. Social Security Number 6.		Ann IIn	for and for independent of the	If Undar 1	BETHI				NTGOME	
rector		577 48 2728	Sex 7 1⊠M 2□F		last birthday) 8 Yrs.			Min. (Mo	e of Birth onth, Day, 9,19	Year) 01	9. Birthplac Country Catlet	t, VA.
N to	-	Usual Rasidence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d.	Inside City Limits
28a-f show	ģ	Maryland Montg	omery		Bethes	da						1X Yes 2 No
or 28.	Lec Sur	10e. Street and Number		1		10f. Zip Co	ode		10	g. Citizen of	What Country	7
23a	<u>e</u>	5721 Grosvenor	Lane			2	0814			United	d State	es
	by Funeral Director	11. Marital Status 1 ☐ Nevar Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceda Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? ŽNo		Vas Deceden Yes, specify I□Yes 20	t of Hispanic Origin Cuban, Mexican, P No Specify:	? (Specify Ye uerto Rican, a	s or No- atc.)		ce - American ck, Whita, etc. y: Blac	
olical	eted	15. Decedent's t	Education rade complated)		16a. Deced	lent's Usual C	ecupation fone during most of	workina	10	6b. Kind of B	usiness/Indus	try
m Me	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)		<i>oo NOT</i> use i	fone during most of etired)			Damba	- Chan	
ither ant, to		17. Fether's Name (First, Middle, Las	it)		<u> </u>	arber	18. Mother's	Name (First,	Middle Mi		r Shop	
c ev	To Be	Unavail	•						avail			
7 is mar traumet		19a. Informant's Name/Reletionship Yvonne Ewell Smi		ter)			treat and Number of					
other	-	20a. Method of Disposition		20b. P	lace of Disposemetery, crem	sition (Name	of	Date	20	0c. Location -	City or Town,	State
7 or 17		1 X Burial 2 ☐ Cremation 3 I 4 ☐ Donation _6 ☐ Other (Spec		T.E.			al Cemete	ry 2/2	6/99	Suitla	and. Ma	rvland
Important; if item 27 is eny injury or other tra once.		21. Signature of uneral Service Lie	**	/-	22	Name and A	ddress of Facility re Funera	1 Serv	ice l	Inc.		
	1	23a. Part. Enter the disaasa, or consider, or heart falure. List only	nplications that caus	ed the death			orgia Ave				Ac	poroximate
ician	1	mock, or heart la ure. List only	y one cause on each	line.			20				Int Or	erval Between aset and Death
edical niner		Immediate Cause (Finat disease or ond n resulting in sell)	PNE	UMONI	A						10	Days
		resulting in death)	α	Due to (o	r es a conseq	uence of):						Dayo
nsit	E		b. CHR	ONIC	OBSTRU	CTIVE :	PULMONARY	DISEA	SE		10) Years
n and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (o	r as a consequ	uenca of):						
ng physician and es the burial-transit	cal	thet initiated events	c	Due to for	as a consequ	lance of	·					
es th	Medical	resulting in death) Last		Due (0 (0)	as a consequ	auriod OI):						
	any		d									
hed fo	Physiciany	Part II. Other algnificant conditions	contributing to death	but not resu	ulting In the un	darlying caus	e given in Part t.	23	b. Did tob	acco use co	ntribute to the	e cause of death?
		DEMENTIA							1 🗆 Yes	8 2□ No	3 Probab	ly 4⊠ Unknown
5 2 4	ed by							248	a. Was an	autopsy		autopsy findings
2 shoul	Completed							_	perform	ed?	compt	ble prior to etion of cause th?
pege 2	E								1 🗆 Yes	2 No	1 🗆 Y	es 2 No
octor octor	Q	25. Was case referred to medical examiner?						Death (Check	k only one)	1	
al dire	0	1 ☐ Yes 2 🗓 No			ER/Outpatient	- 10		ng Home 5[
completely filled in by the funeral	Certification:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation		jury Day Year)	28b. Time of Injury	M 28c.	Injury at Work? 1 ☐ Yas 2 ☐ No	28d. De	scribe how	v Injury occur	red	
ed in by the	Certill	3 Suicide 6 Could not 4 Homicide determined	289. Placa of I	Injury - At ho etc. (Specify	me, farm, stre	eet, factory, of	fice		ation (Stre or Town,		per or Rural Ro	oute Number,
completely filled	edical	29a. Certifier 1 (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the bes miner: On the basis and mannar	of examinat	wledge, death ion and/or Inv	occurred et t astigation, in	ne time, date end p my opinion, death o	lece, and due occurred at the	to the cau tima, dat	use(s) end me e and placa,	enner as state and due to the	d. e cause(s)
com		29b. Signature and title of cartifier	D .				cense numbar		290	_	d (Month, Day	
) dum	tul				37891			Feb.	21,19	99
		30. Name and address of person who	completed cause of	death (Item	23a) (Type, F	Print)						-
			.D., 121									

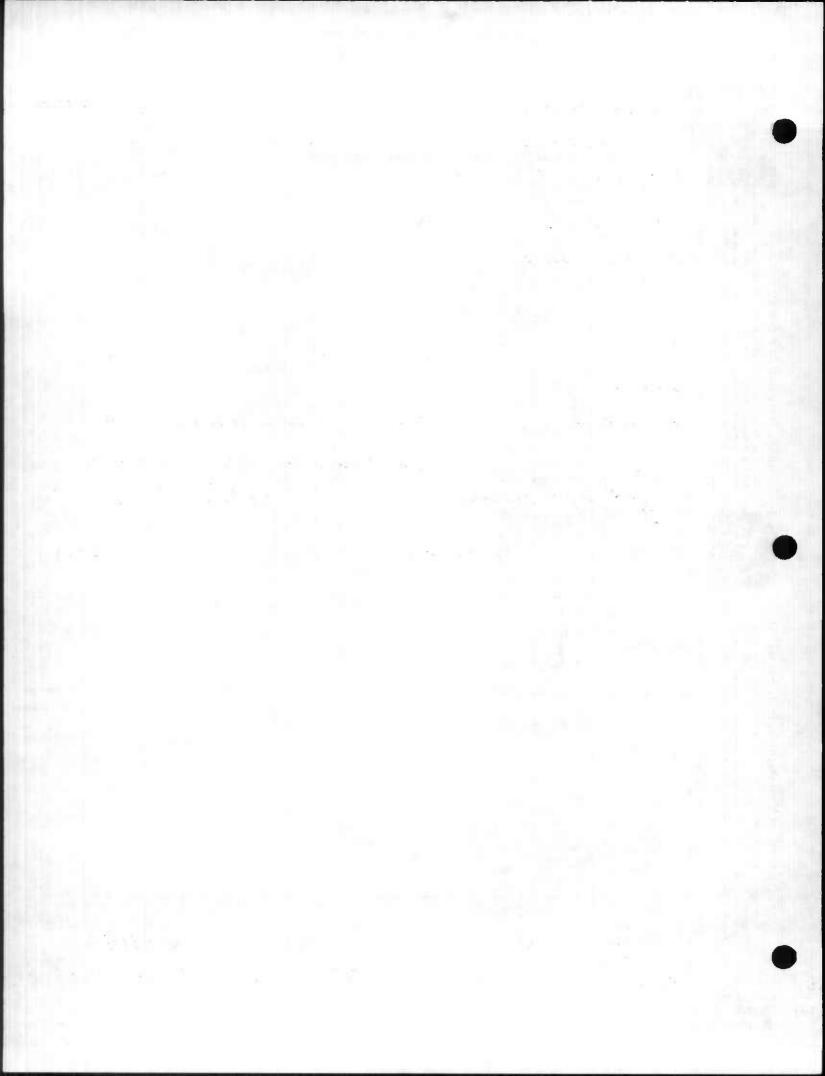
DHMH 16 Rev 6/95

EWELL , JAMES



State of Maryland / Department of Health and Mental Hygiene 9 07 195

				Certificat	e of	Death			Reg. No.		1 1 3 0
	1. Decedent's Neme (First, Middle, L.	ast)						2. Dete of De		Min	3. Time of Death
Physician	Robert Hale E	vans						Month Feb.	22, 199	Year 9	11:15AM
/Medical · Examiner	4a Facility Neme (If not institution, gi					4b. City, To	wn, or Lo	cation of Deat			
Examine	Sacred Heart Hos	nital				Cumbe	rlan	d	A11e	gany	
		-	e (In yrs. last birt	hday) If Unde	1 Year					0	plece (State or Foreign
Funeral Director		1□M 2□F		rs. Months	Deys	Hours	Min.	8. Date of Bir (Month, Da Apr 2	y, Year) , 1914	Cou	plece (State or Foreign ntry) KY
with the Maryland a or 28a-f show the notified at	10a. Stete 10b. County		10c. City, Town								10d. Inside City Limits
Serie No.	MD Allega	ny	Cumbe	rland							21
th with the Mar 23a or 28a-f s unt be notified al Director	10e. Street end Number 205 Baltimore Av	enue		10f. Zij	2150)2			10g. Citizen of V	Whet Cou	ntry?
items ?	11. Maritel Status	12. Was Decedent	Ever in U,S.	13. Was Dece If Yes, spe			igin? (Spe	city Yes or No	- 14. Rac		cen fndien,
	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Ty Yes 2 If Yes, Give Year or Dates:		1 Yes, spe		Specify:		Hican, etc.)	Specify	ck, White, /: Whi	
72 hou 72 hou lical E	15. Decedent's E (Specify only highest gi	ducation		Decedent's Usu (Give kind of wo	el Occuj	ation	t of worki	na	16b. Kind of B		
ed within 72 ho ygiene. ner than "nature rt, the Medical	Elementery/Secondery (0-12)	College (1-4or		`life. DO NOT u	se retire	d)	t of works	<i>'</i> 9	P:		
Maryland 2 12 13-0020 d2 should be filed within 72 hours af th and Markel Hyglens in natural; or traumatic event, the Medical Exam To Be Completed by 6	12 17. Father's Neme (First, Middle, Las	t)	Ure	dit Man	ager		er's Neme	(First, Middle	, Maiden Suman	ance	
should be filed and Mental Hygi marked other matic event, To Be Co	Robert W. Evans					NMN					
ith and Meni	19e. Informent's Neme/Relationship	(Type, Print)							er, City or Town,		o Code)
ealth n 27	Paul Nay-friend						ue C		and MD 2		
Pages 1 nent of H nt: if iten iry or oth	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Spec			Disposition (Ne y, crematory or Gap Vet			0	2/25	20c. Location -		
Deficilizations, Mispositions, Mispositions, Department of Health a Important; if fam 27 le any Injury or other trainance.	21. Signature of Funeral Service Lice		ROCKY	22. Name e			ty		Funeral d MD 215		
	23e. Purt. Enter the disease, or cor	Non								02	Approximete
Physician /Medical Examiner	fmmediate Ceuse (Finel disease or condition resulting in deeth)		Due to (or es e							1	Onset and Deeth
requires that the deeth certificate be executed requires that the deeth certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit eted by Physician/Medical Examine	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated svents resulting in death) Last	b	Due to (or as a c								
attending for use a		d								1	
S, F.O. 500 as that the deeth or gned by the attend be detached for us by Physician.	Pert II. Other significant conditions	contributing to death t	out not resulting in	the underlying	cause gi	ven in Pert	i.		tobacco use co Yes 2 No		to the cause of death obably 4 Unknow
The law requires thet rate has been signed to page 2 should be det								24a. Wes	en eutopsy ormed?	a	Vere eutopsy tindings vailable prior to completion of cause I deeth?
The law ate has be page 2 s								10	Yes 2 No	1	□ Yes 2☐No
certificate irector, pag	25. Wes case referred to medical					26. Plec	e of Deeth	(Check only	one)		
Physician: This cartificant director.	examiner? 1 Yes 2 No	Hospital:	ent 2 PER/Ou	tpatient 3 D	OA Ot	her:			idence 6 🗆 Oth	ner (Spec	ify)
ding Phys h. After this funeral dii	27. Manner of Deeth 1 Neturel 5 Pending	28a. Dete of Inju (Month, De			28c. fnju Wo				how injury occur		
tal or Attanding P rs after death. al Director: After t ied in by the funers Certification:	2 Accident Investigation 3 Suicide 6 Could not determined	be 28e. Piece of In	jury - At home, fe c. (Specify)	rm, street, fecto				28f. Location (City or To	(Street and Numi wn, State)	ber or Ru	ral Route Number,
Hospi 24 hour Funer fely fill	29e. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o end menner st	f examinetion en	, deeth occurred d/or investigation	et the ti	me, date er opinion, dea	nd plece, o ath occurr	and due to the ed et the time,	ceuse(s) end made, date end place,	enner es end due	steted. to the cause(s)
To the within To the comple	29b. Signature and talk of certifler	m D		29	C. Licen	se number	1		29d. Dete ligne	3 9	Day, Year)
mus	30. Name and address of person who	completed cause of CMAGMJ03	deeth (Item 23e)	Type, Print) S	4501	~ 01.	we	cun	BURA	NP,	mo zno
State Registrar	31. Dete filed (Month, Day, Year) FEB 2 6 19		er's Signeture	4. de							



ase Type or Print in Black Indell State of Maryland / Departm					7196	
Certific	ate of Death		J. No.	0 1	1100	
^(e, Last) Olive M. Floreen		2. Dete of Death Month February	Dey 20,	Year 1999	3. Time of 9:45	
on, give street end number)	4b. City, Town, or L			nty of Deeth	2037	

Funeral Director

with the Marylend death

item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Expense must be notified at permit. Pages 1 and 2 should be filed within 72 hours after deat Depertment of Health and Mental Hygiene. Important: If item 27 is merked other than "natural" and page.

Physician /Medical **Examiner**

and buriel-tran physician certificate be the 80 950 0 signed by the a peen pege 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, funeral filled in by

Division of Vital Records, P.O. Box 68760.

Examiner Physician/Medical P Completed Be 2 Certification: Medical

1. Decedent's Name (First, Midd. **Physician** M /Medical 4a Facility Neme (If not institutio Examiner Mariner Health If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sax 8. Date of Birth (Month, Day, Year) 1 M 28 F Months Deys Hours Min 019-22-5872 82 Feb. 24, 1916 Massachusetts Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 1 ☐ Yes 2 ☒ No Director Maryland Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19310 Club House Road #307 20886 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Merried 1 Yes 2 No Specify: Specify: Aq 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be August Westlund Anna Ortegren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Nancy M. Floreen/Daughter 10801 Keswick St., Garrett Park, Maryland 20896 20b. Place of Disposition (Name of cemetery, crematory or other plece) February 22, 1999 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Montgomery Crematorium, Inc. 21. Signatur of Funeral Service Licensee

Robert A. Pumphrey Funeral Home/Bethesda-Chevy
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
To 57 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Partl. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest,

Approximate
Approximate 21. Signature of Funeral Service Licensee Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident Sudden Due to (or as e consequence of): Carotid Stenosis 2 Years Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Multi-infarct Dementia 7 Years Due to (or es e consequence of) Parkinson's Disease 10 Years 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2K No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes an autopsy performed? 1 ☐ Yes 21 No 1 Tyes 2 □ No 25. Was cese referred to medical 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of injury 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Drell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D20065

29d. Date signed (Month, Day, Year) February 22, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Eva M. Morell, M.D.

6000 Executive Blvd. #300, Rockville, Maryland 20852

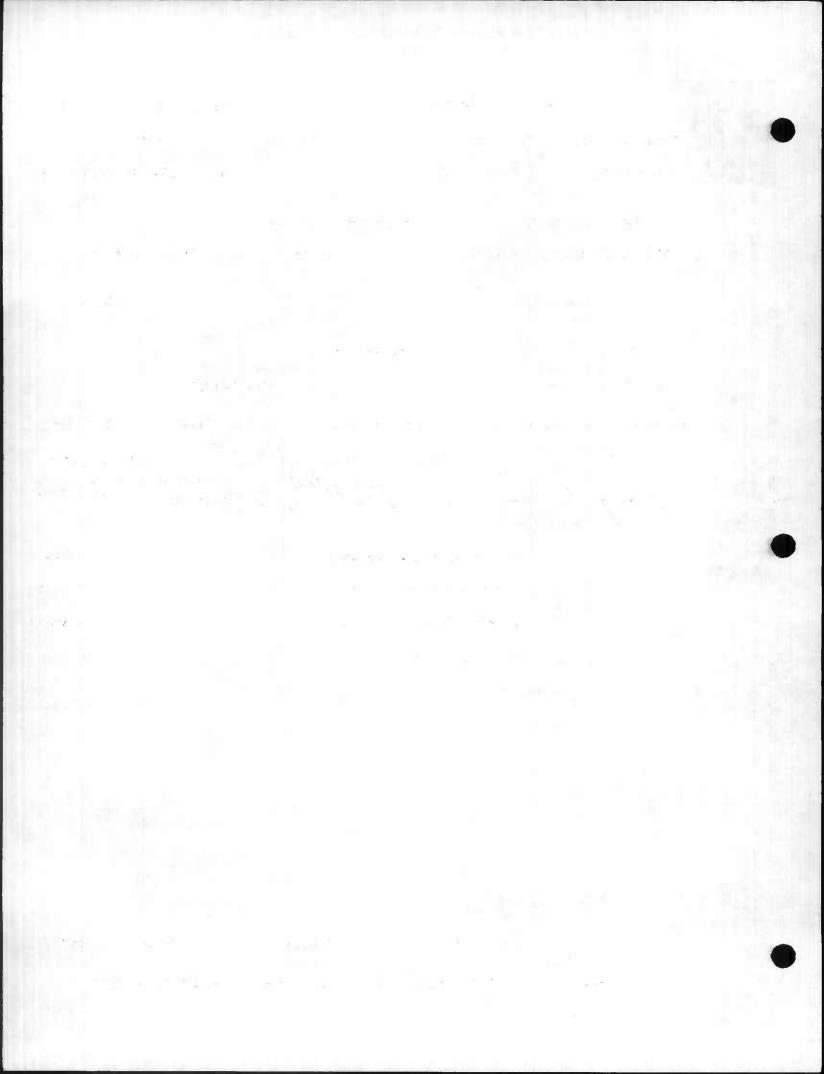
State Registrar

completely

31. Date filed (Month, Dey, Year) FEB 2 3 1999

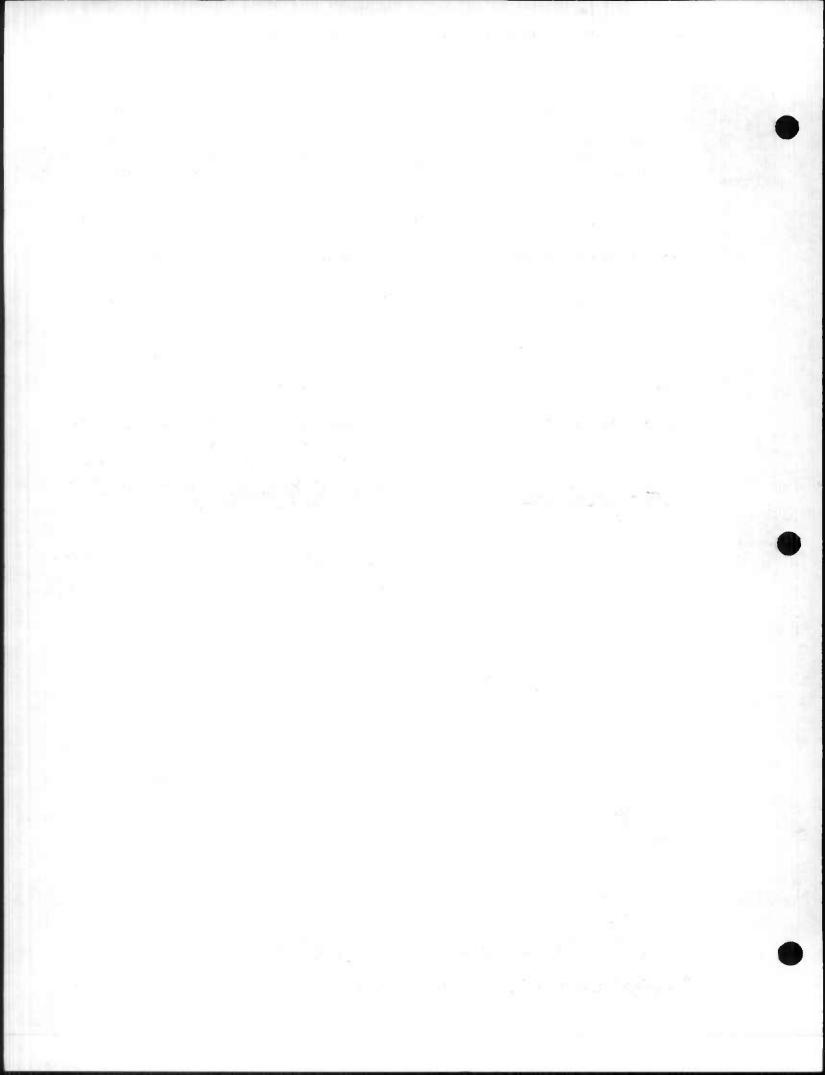
6 Could not be determined





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician		1. Decedent's Neme (F					rtificate of		2. Dete of Deet	h Day	Yaar 3	. Tima of Death
/Medical				ia A. Fo					Month Februar			1:19 PM
xaminer		la. Facility Name (If no Suburban)			4b. City, Town, or Lo Bethesd		4c. County	of Death tgomer	v
neral ector		5. Social Security Num 096-30-688	6. Se		ge (In yrs. 87	last birthday) Yrs.	If Undar 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 20			(State or Forei
**	-	Usual Residence of De 10a. State 10	ocedent Ob. County		10c. Cit	y, Town or Lo	cation				10d.	Inalda City Limi
Director		Maryland 1	Montgome	rv	Ch	evy Ch	ase					1⊠ Yas 2 1
Director		10e. Street and Number					10f. Zip Coda		10	Og. Citizen of V	What Country?	
rai C		5610 Wisc	onsin Av	enue #17	F		2081	5		United	States	5
odical Examiner must	2	 11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☑ 		12. Was Decedent Armed Forces' 1 ☐ Yes 2 1 1 If Yes, Give Yaar or Dates:	?		Vas Decedent of H f Yas, specify Cuba I ☑ Yes 2☐ No	dispenic Origin? (Spi an, Mexicen, Puarto Specify: Cub		Blac	e-Amarican i ck, White, etc. White	
Completed		(Specify of Elementery/Seconds	Decedent's Edu only highest grad ary (0-12)	cation e co <i>mpleted)</i> College (1-4or	5+)	life. I	lent's Usual Occup kind of work done DO NOT use retired Teacher	pation during most of works d)	ing	16b. Kind of Bu	usiness/indust	
Be Co	3	17. Father's Name (Firs	st, Middle, Last)	2			reacher	18. Mother's Name	e (First, Middle, N			
To Be		Benito A.						Concepc	ion Gira	ud		
E		19e. Informant's Name	Reletionship (T)	rpe, Print)	2	19b. Meilir	ng Address (Street	end Number or Rure	el Route Number,	City or Town,	Stete, Zip Cod	de)
100		Elda M. Ph		aughter				n Ave.,#1				
any injury or other tra		20a. Mathod of Disposi 1 ☐ Burial 2 🛣 C 4 ☐ Donation 5	Cramation 3 ☐F ☐ Other (Specify)		C	ntgome:	ry Cremat	Feb. 26,	, 1999 nc. B	ethesda	a, Mary	land
any in		21. Signatum of Funer	al Service Licens	ea C	M001	.98 Ro	Name and Addre bert A. 557 Wisc ethesda	Pumphrey onsin Ave Maryland	Funeral nue 20814-		ethesda Chase,	a-Chevy Inc.
ian		23a, Part1, Enter the d shock, or heart fe	disaasa, or compl pilure. List only or	ications that ceuse ne ceuse on eech l	d tha deat ine.	h. Do not ant	ar tha moda of dyir	ng, such es cardiac d	or raspiratory arre		Inte	proximate ervel Between sat and Death
ical ner		Immadiate Cause (Find disaase or condition resulting In death)	ai	Int.A	CRA	MAL /	Hemirho	se.		· <u> </u>	4	Hrs
ial-transit Examiner				Hyp	enter	Scur	VASCULL	n Desec	se		1	Hrs 0 + yea
the bu		Sequentielly list condition of any, leeding to Imme cause. Enter Underlyin Cause (Disease or injusthat initiated events resulting In death) Lest		o		r as e conseq						
etached for use as Physician/Med			L ,	d	<u> </u>							
d by Physician/N	F	Part II. Other significer	nt conditiona cor	tributing to death t	out not res	uiting in the ur	nderiying cause giv	ren in Part I.	23b. Did to	bacco usa coi	ntribute to the	cause of dea
be detac									1 🗆 Ye	2 2000	3 Probabl	y 4 Unkn
2 shou									24a. Was er perform	n eutopsy ned?	availat	autopsy finding ble prior to ation of ceuse th?
Com									1 □ Ye	s 2000	1 □ Ye	a 2□No
Be Be	1	25. Wes case referred examiner?		lospital:	do		Oth	26. Plece of Deeth				
e funeral dire		7. Manner of Death	Pending Investigation	1 ☐ Inpati 28a. Dete of Inju (Month, De	IIV (28b. Time of Injury	28c. Injur Wor	4 Li Nursing Ho	me 5 Reside 28d. Describe ho			
led in by the funera Certification:			Could not be determined	28a. Place of In building, et	jury - At ho c. (Specify	ome, farm, str	eet, fectory, office		28f. Location (Str City or Town		er or Rural Ro	outa Number,
8 0		29a. Certifier 1	Cartifying Phys Medicel Examin	nician: To the best nar: On the basis of and manner st	f examinat	wledge, deeth tion and/or Inv	occurred at the tin astigation, in my o	ne, date end piece, pinion, death occurr	end due to the ce ed at tha tima, da	use(s) end me ate and place,	enner es stated end due to the	d. cause(s)
pletely filled edical C		one)										
completely filled			of certifier				29c, Licans	a number	29	d. Data signed	d (Month, Dey	, Year)
pletely fill edical		one)	7	en her	0		1	a number 32610 Bethes da			-	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Dev **Physician** February 18, 1999 1:20 AM Vivian P. Fouts /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Rockville If Under 24 Hrs. Rockville Nursing Home Montgomery If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1□M 2\ F Months Deys Hours Yrs. 233-05-4029 92 Director January 13, 1907 Pennsylvania Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Example must be notified anone. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Adclare Road 20850 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 14. Rece - American Indian. 11. Maritaf Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 K No Specify: Specify: þ White 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede com 16a, Decedent's Usuei Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) completed) Department Elementery/Secondery (0-12) College (1-4or 5+) 12 Accounting Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Vincent Anderson Helen Not Available 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 15120 Westbury Road, Rockville, Maryland 20853 James E. Crickey, Jr. 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) February 22, Dete 1999 20c. Location - City or Town, Stete Silver Spring, 20e. Method of Disposition 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Maryland Pumphrey Funeral Home/ 22. Name end Address of Fecility Robert A. 300 West Montgomery Avenue, Rockville, Inc. Rockville, Maryland 20850-2806 M00689 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Approximate tntervat Between Onset and Death Physician /Medical Immediate Ceuse (Finet disease or condition resulting in deeth) . Cardiac Arrhythmia Examiner Due to (or es a consequence of): Examiner b. Dementia physician and s the burial-transit that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): SB Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2♥ No 3 Probably 4 Unknown P The law requires 24b. Were autopsy findings available prior to Completed 24e. Wes en autopsy completion of cause of death? is certificate has director, page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4√ Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpetient 2 ER/Outpetient 3 DOA funeral 28d. Describe how Injury occurred 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 X Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of trijury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide C To the Hospital or within 24 hours aft To the Funeral Di completely filled in 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of certifier 29c. License number

State Registrar 31. Dete filed (Month, Dey, Year)
FEB 2 3 1999

Frauke Westphal, M.D.

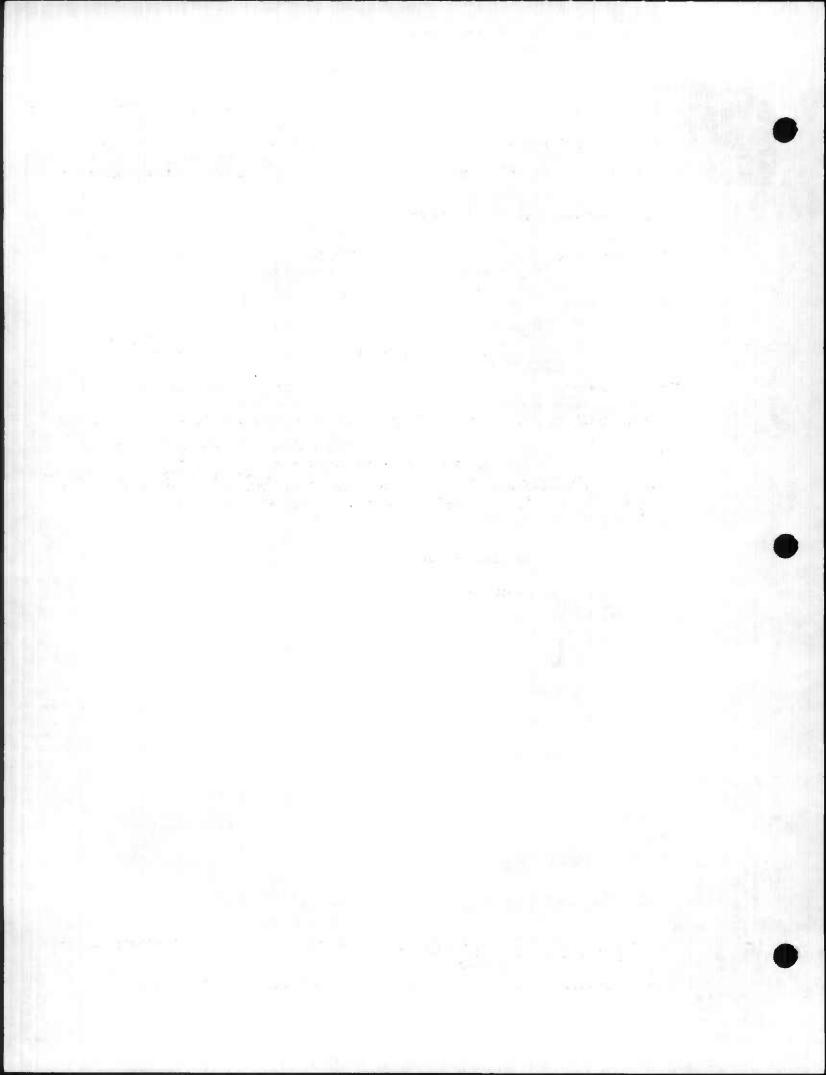
30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

809 Veirs Mill Road, Rockville, Maryland 20851
32. Registrar's Signeture 6.

D19785

February 18, 1999

D



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** 23, 1999 FEBRUARY 1:10 A.M. ETHEL M. FROGH /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** SPRINGBROOK ADVENTIST NURSING HOME SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 200 F Yrs. JUNE 16, 1901 MINNESOTA Director 351-24-4795 Usual Residence of Dacedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-f show the Medical Experimen must be notified at 1 Yes 2X No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 1005 VENICE DRIVE 20904 Funeral Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Black, White, etc. 72 hours efter 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No If Yes, Give 1 Yes 2 No Specify: Specify. p 3 X Widowed 4 Divorced Year or Detes: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Sacondary (0-12) Collega (1-4or 5+) permit. Peges 1 end 2 should be filed w Department of Heelth end Mental Hygien Important: If Item 27 Is marked other th any Injury or other traumatic event, Internate. NEWSPAPER INDUSTRY 12 0 ADD TAKER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be JAMES S. SHEEHAN MATHILDA KURKOWSKI 19a. informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS M. OWENS - DAUGHTER 1005 VENICE DRIVE, SILVER SPRING, MARYLAND 20904 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-27-99 BRENTWOOD, MARYLAND LINCOLN CREMATORY 21. Signature of Funeral Service Licensee 22. Name end Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 2090 Ah Approximata intarval Betwean Onset and Death Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Our only one cause on each line. **Physician** /Medical Immediata Causa (Final a GANGRENE OF LEG AFTER AMPUTATION disease or condition rasulting in death) 2 WEEKS Examiner Due to (or as a consequence of): Examiner PERIPHERAL VASCULAR DISEASE 10 YEARS bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): end physician sthe bunel certificate be an/Medical Due to (or es e consequence of): 80 ed by the attending detached for use es Physici 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 ☐ Yes 2 No 3 Probably 4 Unknown DEMENTIA þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed peen EMPHYSEMA completion of cause of death? hes 1 Tyes 2 No 1 Yes 2 No director, 25. Was case raferred to medical examiner? Be 26. Placa of Death (Check only one) Othar: 4₺ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural Attending injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation i or Attendi efter death Director: A 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Spacify) 6 4 Homicide To the Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number D43237 FEBRUARY 25, 1999 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) PAUL ARMSTRONG, 14201 LAUREL PARK DRIVE, #102, LAUREL, MARYLAND 20707-5298 M.D.,

State Registrar 31. Date filad (Month, Day, Year)

FEB 26

32. Régistrar's Signature

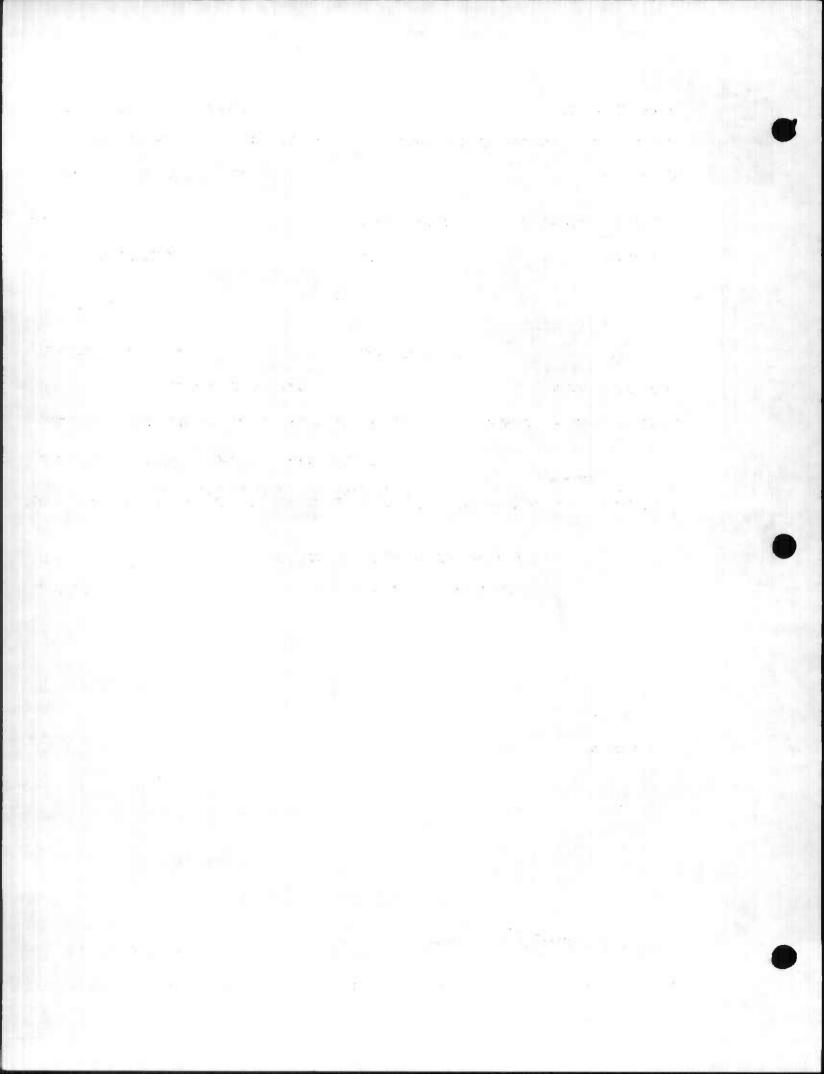
Baltimore, Maryland 21215-0020

Box 68760

P.0.

Records,

Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q 0 7

				Ce	rtificate of			Reg. No.	016.00
Physici	an	Decadant's Nama (First, Middla, Last					2. Data of De Month	eath Dey Ya	3. Time of Death
/Medi		Hazel L. Fogl					Feb. 2		3:00 A.M
Examir	ner	4a. Facility Nama (If not Institution, give	straat and number)			4b. City, Town, or I	ocation of Deet	th 4c. County of E	Death
		469 Goethe Stree	t			Cumber1a:		Allega	iny
Funeral		5. Social Security Number 6. S		a (In yrs. last birthday)	If Under 1 Yeer Months Days	If Undar 24 Hrs. Hours Min.	8. Deta of Bii (Month, De		Birthplaca (State or Foraign Country)
Director		218-34-4296 Usual Rasidanca of Decedent	□ M 2∏ F	77 Yrs.	Months Days	Tiours iviii.	April		est Virginia
72 hours effer death with the Maryland netural, or items 23s or 28s-f show olds! Examiner ortal be redified at	2	10a. Stata 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
the M	Director	Maryland Allegany	У	Cumber	1and 10f. Zip Coda			40-07	
E S					Tot. Zip Coda			10g. Citizan of Whe	t Country?
ath 23	ral	469 Goethe Street			2150			USA	
172 hours effer death with the Marylar neturer, or flame 23s or 28s-f show polical Examiner count be notified at	Funeral	11. Meritel Stetus 1 ☐ Navar Married 2 ☐ Merriad	12. Was Dacadant 8 Armed Forcas? 1 ☐ Yas 2 🗓 N	lo	Was Decedent of I If Yes, specify Cub		pacify Yes or No o Rican, etc.)	14. Raca - / Biack, V	Amaricen Indien, Vhite, etc.
al', o	by	3 ☑ Widowad 4 ☐ Divorced	If Yes, Giva Year or Detes:		1 ☐ Yes 2 No	Specify:		Specify:	White
2 ho	ted	15. Decedant's Ed	ucetion	16e. Deca	dant's Usual Occup	pation		16b. Kind of Busine	
G 1 5	Completed	(Specify only highest gra Elamantary/Secondary (0-12)	da complatad) Collega (1-4or 5	+) (Giva	kind of work dona DO NOT usa retire	during most of wor d)	king		
	S	12		(Cook			Restaura	ant
be file d othe event,	Be	17. Fathar's Nama (First, Middle, Last)				18. Mothar's Nan	ne (First, Middla	, Maidan Sumema)	
	2	Grover Cleveland				Mary M			
		19e, Informent's Name/Ralationship (7	Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	per, City or Town, Ste	te, Zip Code)
s 1 end sift Health item 27 I		Phyllis C. Walsh/	Daughter		oethe St.	. Cumber1	and, Md	. 21502	
		20e. Mathod of Disposition 1 Burial 2 □ Cramation 3 □		20b. Place of Dispo cematary, cra	osition (Nama of matory or other pla		Feb-	20c. Location - City	or Town, Steta
rtant njury		4 Donation 5 Other (Specify		Sunset Me			26,1999	Cumber1a	nd,Maryland
permit. Pages Department of Important: If i any injury or once.		21. Signatura of Funeral Service Lican	. 0	L		tein Fune		e 230 Bal	timore Avenu
_		23a. Part1. Entar tha disaasa, or comp	olications that caused	tha death. Do not an	Sumberland tar the mode of dyl			arrast,	Approximata Intarval Batween
Physician		shock, or haart failura. List only	ona causa on each iin	a.	-1	1			Onset and Death
/Medical		Immadiata Cause (Final disaasa or condition	. Deut	to sohi	Tans -	Lee Reo,	2.		> f.
Examiner		resulting in death)	a	Due to (or as a conse	quance of:	the state of the s			
n =	ner			e)are	ea P	2.			12 480
nd	Examiner	Sequentially list conditions,	U.	Dua to (or as a consac					
e exe	EX	Sequantially list conditions, if any, leading to Immadiata causa. Enter Undarlying Causa (Disaasa or injury		2. K.F					3 70
ifficete be executed g physician end es the buriel-trensit	edical	that initiated evants rasulting in death) Lest	c.	Dua to (or as e consec	quence of):				10
	-	COLUMN TO THE REAL PROPERTY.	. (a lu	ug		/	11/	37ev
deeth cert e ettending ed for use	lan/		0.		1			Xe ho	FeB 2/4/99
0 0	Sic	Part II. Other significant conditions co	entributing to death bu	it not resulting in tha u	indarlying causa gi	van In Pert I.	23b. Did	tobaceo use contrit	oute to the cause of death
± 60	/ Physician/N						10	Yes 2□No 3E	Probably 4 Unknow
uires the signed Id be del	d by						24a Was	an autopsy 2	4b. Wara autopsy findings
- D 0	Completed							ormed?	available prior to completion of ceuse of death?
0 - 0	mo.						10	Vac division	
iclan: The		25. Was case referred to medical				00 81			1 ☐ Yas 2 ☐ No
Physician: this certific ral director,	o Be	25. Was casa referred to medical examinar?	Hospital:		Ott	28. Placa of Dee	1		
Physer this	n: To	27. Manner of Death	28a. Deta of Injur		IL SLI DOA	4 LI Nursing H		idanca 6 Othar (S	Specify)
ath. Ath	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accidant Invastigation	(Month, Day	Year) Injury		Yas 2□No			
if or Attending P safer death. I Director: After t d in by the funera	Certification:	3 ☐ Suicida 6 ☐ Could not be datarminad	28e. Place of Inju	ry - Al homa, farm, str . (Spacify)	reat, factory, office		28f. Location (City or To		r Rural Routa Number,
ral D	- 1								
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Cartifiar 1 Certifying Phy (Check only one)	rsician: To the best of inar: On the bests of and mannar state	f my knowledga, daatl axamination and/or in tad.	h occurred at the til vastigation, in my o	ma, data and place opinion, daath occu	, and dua to tha rred at the time,	causa(s) end menna date end place, and	r es stated. dua to the causa(s)
To the To the Comple	Me	29b. Signeture end title of certifiar			29c. Licans	sa number		29d. Date signed (N	fonth, Day, Year)
->-0) Il am		75	2	5 83 7	7	2-201.	59.
4		20. Name and address as a summer	omniated assessed	orth (Bears 2001) CT		ر ده ر	*	5-24.	()
Day		30. Nama and addrass of person who c							
	• 0	Uriel E. Velandia 31. Data filed (Month, Dey, Yaer)	32 Registre	2 Seton Dr r's Signatura	ive Cumb	erland, M	ld. 2150	12	
Sta Registr	_	FFB 2 5 1999	CZ II logistio		Lund	,			

and the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Daath Month 3. Time of Death Year FEBRUARY 24 1999 SARAH ELIZABETH FREY 4:00 AM 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death 715 FAYETTE STREET CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Sacurity Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Birthplece (Steta or Foreign Country) 1□M 2\ F Yrs. W. VA. 577-24-0452 80 SEPT 13 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MARYLAND ALLEGANY CUMBERLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 715 FAYETTE STREET 21502 U.S.A. 12. Wes Dacedent Ever in U,S. Armad Forces? 1 ☐ Yes 2 ☒ No It Yes, Giva 13. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced 16e. Dacedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 +ART INSTRUCTOR EDUCATION 17. Fether's Neme (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surneme) JAMES FRED NEILL ELLEN TRAMMELL 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUGENE L. FREY HUSBAND ND 715 FAYETTE STREET CUMBERLAND MARYLAND 21502 20b. Pleca of Disposition (Nema of cematery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Mathod of Disposition Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) ROSEDALE CEMETERY MARCH 1 1999 MARTINSBURG, W.VA. Signature of Funeral Sarvica Licensee 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME emil 404 DECATUR STREET CUMBERLAND MARYLAND a. 23e. Part1. Enter the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximeta Interval Betwe Onset and Death discare immediete Causa (Finel disease or condition rasulting in deeth) Due to (or as e consequence of) Dua to (or es e consequence ot): 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown 24b. Ware eutopsy tindings available prior to 24e. Wes en eutopsy

Physician /Medical **Examiner**

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tras

Physician

/Medical

Examiner

10e State

Director

Funerai

à

Completed

Be

Funeral

Director

Peges 1 end 2 should be filled within 72 hours efter death with the Marylend nent of Health end Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow

Baltimore, Maryland 21215-0020

d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at

traumetic

Examiner Physician/Medicai by Completed Be 2

nding physician end use es the buriel-transit USB BS signed by t Certification: I Director: / ed in by the within 24 hours a
To the Funeral D
completely filled

certificate hes

After this

the Hospital or Attending Physician:

death.

efter

Sequentially list conditions, if any, leeding to immediata cause. Entar Underlying Ceuse (Disaesa or Injury that initiated events rasulting in deeth) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☒ No 25. Was case reterred to medical 26. Plece of Deeth (Check only ona) 1 ☐ Yes Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa Rasidence 6 Othar (Specify) 27. Mennar of Deeth 28e. Data of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be datermined 3 Sulcide 28e. Plece of Injury - At home, term, streat, tactory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Certifier (Check only one) The certifying Physician: To the best of my knowledge, daeth occurred et the time, deta and plece, end due to the causa(s) end mannar as steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete end placa, end due to the cause(s) end mennar steted.

D 33280

29b. Signeture and title of certify

29c. Licensa number 29d. Data signed (Month, Dev. Year)

completion of cause of daeth?

1 ☐ Yes 2 ☐ No

FEBRUARY 24 1999

30. Name end address of parson who completed causa of deeth (Item 23a) (Type, Print)

DR SUNIL K. GUPTA 31. Dete filed (Month, Day, Year) FEB 2 5 1999 625 KENT AVE. CUMBERLAND MARYLAND 21502

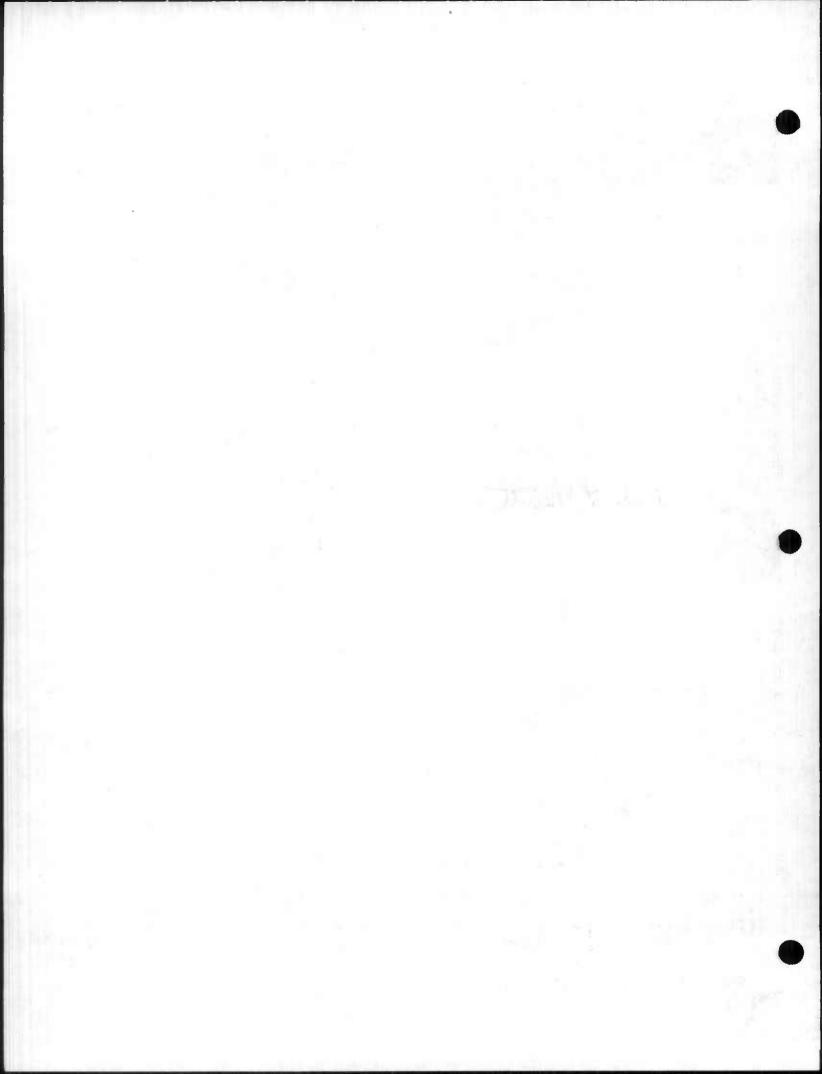
State Registrar

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Medicai

32. Registrer's Signetura





State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death 13 WILLIAM Month FEB **Physician** LAFAYETTE 1999 GARRETT 6:42 AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner LETHES IN S. Date of Birth (Month, Day, Year) Sept. 24, 1920 Texas NATIONAL NAVAL MEDICAL CENTER LETHESTA MONTGOMERY If Under 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 12XM 2□ F 78 Vre Director 461-16-4696 Usuat Residence of Decedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, the Medical Examiner must be notified at 10d. Insida City Limits 1 Yas 2 No Director Fairfax Co. McLean Virginia 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? with 1 7008 Sea Cliff Road 22101 USA daath 12. Was Decedant Evar In U,S. Armed Forcas?

1 12 Yes 2 1 No If Yes, Giva Year or Datas: 1973 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status 14. Race - American Indien, Black. Whita, atc. 2 should be filed within 72 hours effer and Mental Hygiena. is marked other than "natural", or item 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentery/Sacondary (0-12) Collega (1-4or 5+) Captain U.S. Navy 12 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Malden Sumame) Be William L. Garrett, Sr. 2 Mira Murphy 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pegas 1 and 2 sh Depertment of Health end Important: If Item 27 is m any Injury or other traum once. Virginia A. Garrett (Wife) 7008 Sea Cliff Rd, McLean, VA 22101 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Dete 1 € Burial 2 □ Cramation 3 □ Removel from State Arlington National Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Arlington, VA 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Murphy Falls Church Funeral Home 1102 W. Broad St, Falls Church, VA 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsel end Death **Physician** /Medical Immediata Cause (Finel disease or condition resulting in death) NON SMALL CELL LUNG CANCER Examiner Due to (or as a consequence of): Examiner physician end s the buriel-transit Sequentially list conditions, if eny, leading to Immediate causa. Enter Underlying Causa (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): certificate be axecu Box 68760 Physician/Medical Due to (or as e consequance of): as esn jo P.0. ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detact 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 🛣 Unknown Records, P 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy has paga 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Attanding Physician: funeral director, 25. Was casa referred to medical examinar? Be 26. Placa of Daath (Check only one) Hospitat: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 ☐ Yas 2 ☑ No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Data of tnjury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending death. 1 ☐ Yas 2 ☐ No investigation or Attand efter death Director: / 6 Could not be detarmined 3 Suicida 28a. Place of Injury - Al homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 2 4 Homicida filled in e Hospital of 24 hours e 29a. Certifian Medica 1 🔀 Certifying Physicien: To tha best of my knowledge, daath occurred at tha tima, date and plece, end dua to the causa(s) and mennar es statad. npietaly (Check only 2 Medical Exeminar: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and plece, and due to the ceuse(s) and menner slated. Within 2 29b. Signature and titla of certifier 29c. Licansa number 29d. Dela signed (Month, Dey, Year) 2-16-99 16000 (MS) anni NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of deeth (Item 23e) (Typa, Print) DAVID E. ALLEN, LT,MC, USNR BETHESDA MD 20889-5600 31. Data filed (Month, Day, Year)

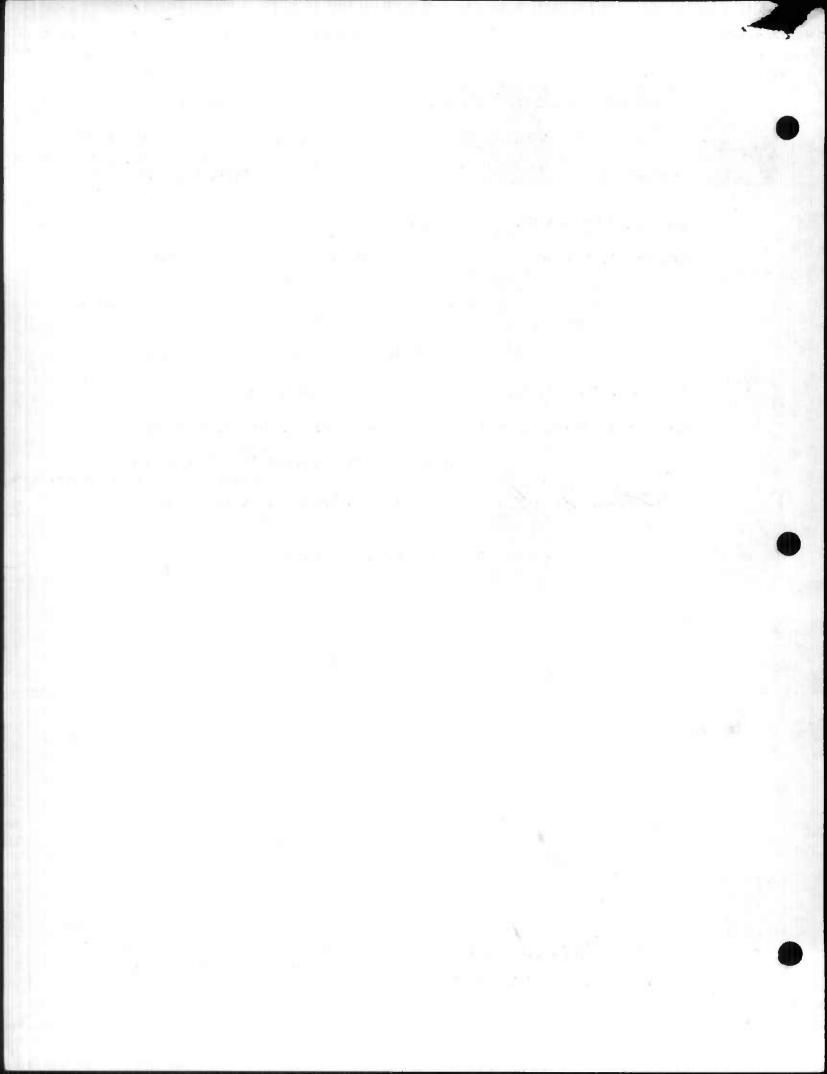
Registrar

State

FEB 24 1999

32. Registrar's Signatura

Annell



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 2215 **Physician** MARIO CURRY (-AT 4551 FEBRUARDY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BETHERON 5005 FORT SUMWER DRIVE MONTGOMONY If Under 24 Hrs. Hours Min. If Under 1 Year 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1₩ 2□ F Months 83 004-16-5392 Director JAN. 21,1916 MASS Usuel Residence of Decedent the Merylend 10e State 10d. Insida City Limits 10b County 10c. City. Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show treumetic event, the Madical Examiner must be notified at 1 Ves 2 No Director MD. MONTGOMERY BETHESDA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A.

14. Raca - American Indian,
Bleck, White, etc. 20816 5005 FORT SUMNER DR. Funeral death 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedant Ever in U,S. Armed Forces? 11. Marital Status 1 A Yes 2 No If Yes, Give Year or Detes: WWII 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) NAVAL OFFICER U.S. NAVY 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) . Peges 1 end 2 should be fili ment of Health end Mentel Hy lant: If Item 27 is marked oth jury or other trsumatic even PASQUALE GALASSI MABEL CURRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 5205 NAHANT ST., BETHESDA, MD. 20816 NICHOLAS M. GALASSI/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) permit. Pege Depertment of Important: if any injury or once. CHAMBERS CREMATORY 2/20/99 Riverdale, Md. 21. Signeture of Funerel Service Licensee 22. Nama end Address of Facility 20910 MOOO91 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onsat and Death Physician ATHOROSCUMUTIC CANDIOUNSCULM DISTORE /Medical Immediete Ceuse (Final disease or condition rasulting in death) Examiner Due to (or es e consequença of) Examiner physician end s the buriel-trensit Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): Se 950 23b. Did tobacco usa contributa to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 4 Unknown ASSTIC ANGURYSM 1 Yes 2 No 3 Probably Division of Vital Records, à 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en autopsy Completed HYPOTHYLOIDIN certificate hes tirector, page 2 s 2000 1 Yes 1 ☐ Yes 2 No Hospital or Attending Physician: funeral director, 26. Place of Deeth (Check only one) Be 25. Was case referred to medical 1 Ves 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. tnjury et Work? 28a. Dete of tnjury (Month, Day Year) Natural 5 Pending efter death. 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 124 hours 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steled.

Medical Examinar: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) end manner steted. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical 29b. Signatur 29c. License number 29d. Data signed (Month, Day, Year) and title of certifier FEBRUSS 19, 1999 9+1 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 11/25 DOCKILLE PIKE, POCKVILLE, MO 20852 10 I magous mo. (OME) 31. Date filed (Month, Dey, Year) FEB 2 2 32. Registrar's Signeture State 1999 Registrar

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DHMH 16 Rav 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's N	ame (First, Middle, La	st)		Cer	tificate o	r Death	2. Date of De			Time of Death
hysician /Medical	Rosalia	Agnes Gil	1					Februa	ry 21, 1	999	8:00 PM
xaminer		e (if not institution, giv		er)			4b. City, Town,	or Location of Deat			
Adminion	Brooke	Grove Nurs	ing Home				01ne	V		gomery	
neral	5. Social Securit		0	Age (In yrs. I	ast birthday)	If Under 1 Yea		3		0 3	/State or Foreign
ector	217-12- Usual Residence	5646	□ M 2 🖾 F {	80	Yrs.	Months Day	s Hours N	Min. 8. Dete of Bi (Month, Di Octobe:	r 30, 191	8 Pen	(State or Foreig nsylvani
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co E	MD	Montgom	ery	Si	lver S	pring					1 ☐ Yes 2 ☑ No
Dire	10e. Street and					10f. Zip Code			10g. Citizen of \	What Country?	
Ta Ta	1400 S	tateside D	rive				20903		USA		
the Medical Eventines must be notified at completed by Funeral Director	3 🖾 Widowe	s arried 2 Married d 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? No		Vas Decedent of Yes, specify Cu ☐ Yes 2 N		7 (Specify Yes or No uerto Rican, etc.)	Specify	e - American II ck, White, etc. White	
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Be		ce Edgar S						Name (First, Middle		10)	
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To		Name/Relationship (r Rural Route Numb			,
		E. Gill/S	on					Ct.Gaith	ersburg	, MD 20	882
	20a. Method of D	Disposition 2 ☐ Cremetion 3 ☐	Removal from Stat	20b. Pl.	ace of Dispos metery, crem	sition (Name of atory or other p	(ace)	Dete	20c. Location -	City or Town,	State
		n 5 Other (Specify		Ga	te of	Heaven	Cemetary	2/26/99	Silver	Srping	, MD
- 5000	Ma	Funeral Service Licen) 200		22. Hot	Name and Add	ress of Facility F 500 U ing, MD	rancis J. niversity	Colling Blvd.	s Funer West	al
an al	23a. Part1. Ente shock, or h Immediate Caus disease or cond resulting in dealt	tion	Λ	ZATIOA		EU MON		diac or respiratory a	rrest,	Inte	proximate erval Between set end Death
	resulting in death	"			as a consequ	uenca of):					
Examiner			b. DYSP+							7 1	DAYS
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100	Sequentielly list if any, laading to cause. Enter Un Cause (Disease	derlying or injury	· HEUTE	CER	EBRAL	. FNI	FARCT			46	SAYS
n/Medical Examir	that initiated eve resulting in death	nts	d	Due to (or	es a consequ	ence of);					
Physician/N	Part II Other ale	- Maria						1			
Physician/N	Part II. Other sig	nificant conditions co	ontributing to death	but not resul	ting in tha un	derlying cause (iven in Part I.		tobacco use cor Yes 2□ No	ntributs to the 3 ☐ Probably	
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Be (25. Was case ref	erred to medical					26. Place of [Death (Check only o	nne)		,
To	examiner?	Z No	Hospital:	ienf 2□ E	R/Outpetient	3□ DOA O	44	g Home 5 ☐ Resid		or (Specify)	
	27. Mannar of De	ath	28a. Date of Inj	jury 2	28b. Time of	28c. Inj			now injury occurr		
읈	1 Naturai 2 ☐ Accident	5 Pending investigation	(Month, D	ay Year)	fnjury		ork?]Yes 2∐No				
Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be	28e. Placa of Ir	njury - At hon atc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (City or Tox	Street and Number, State)	er or Rural Rou	ute Number,
edicai	29a. Certifiar (Check only one)	1 Cartifying Phy 2 ☐ Madical Exam	iner: On the basis of	of examinatio	ladge, death on and/or inve	occurred at the testigation, in my	ima, date and pla opinion, daath o	aca, and due to tha	causa(s) and ma	nnar as stated	cause(s)
Medical Certifi			and manner s	tated.							and the same
	29b. Signature ar	C A Certifier	. ~			29c. Licer	ise number		29d. Date signed	(Month, Day,	Year)
		COLOUR	e. m)			001	033700	1	February	22.1	1999
	30. Nama and ad	dress of person who c	ompleted cause of	death (Itam 2	23a) (Type, P	rint)					
	TED	E. HALLE	75	42 0	VERI	SOK A	PIVF 1	Boonsison	N OS	717	113
State	31. Data filed (Mo	onth, Day, Year)	32. Regist	rar's Signatu	ire	0	-100	NAINO			

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	30. Name end edd	dress of person who	completed cause	of death (ite	em 23e) (Type,			. Lank	am, m.	d. 20	0706

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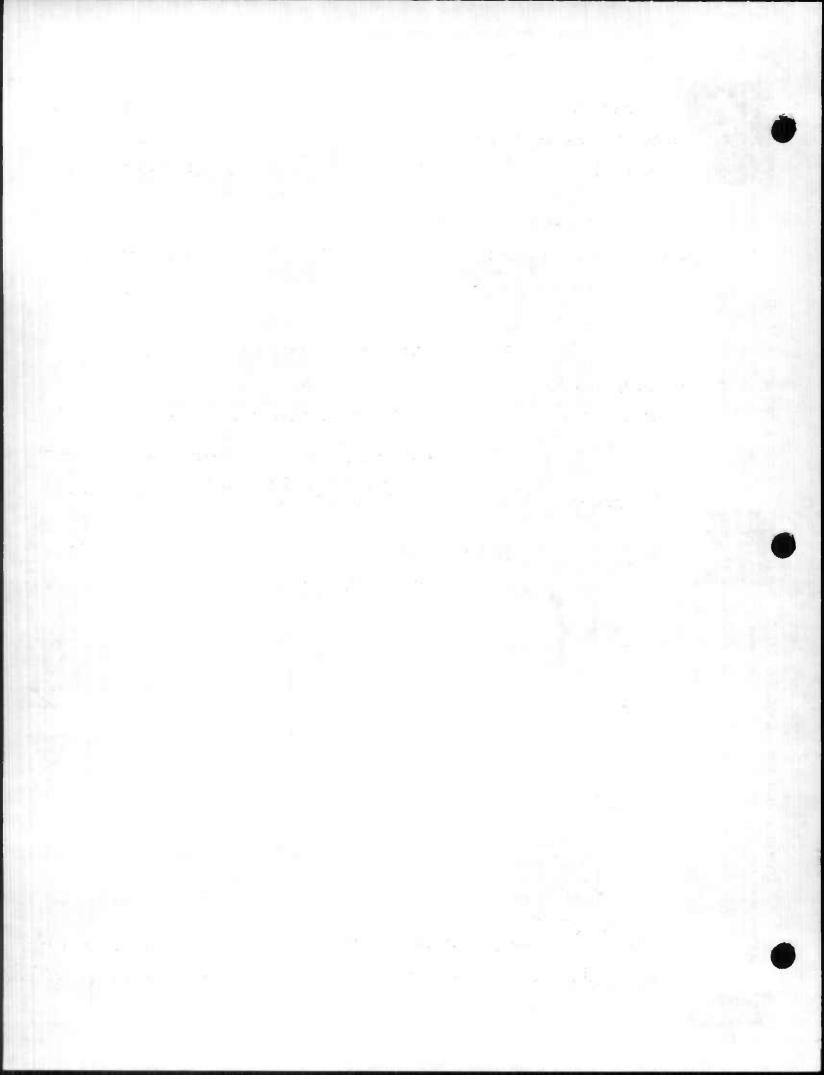
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Feb. 1999 11:15pm Frances A. Gruner /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Montgomery General Hospital Montgomery Olnev If Under 24 Hrs. 8. Date of Birth Hours Min. Sept. 18, 1912 Pennsyl Vania If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** 1 M 2 K F Months Deys 234-32-8371 86Yrs. Director Usual Residence of Decedan the Maryland 10d. Inside City Limits 10e State 10b. County 10c. City. Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Directo Marvland | Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 20906 United States 14514 Homecrest Road, Apt. LL-2 death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 end 2 should be filed within 72 hours effer to Department of Health end Mental Hygiena. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Mexical Examines once. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify Specify: White by 3 Nidowed 4 Divorced Completed 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decadant's Usuai Occupation (Give kind of work done during most of working life. DO NOT usa retired) Elamantary/Secondary (0-12) College (1-4or 5+) Administrative Assistant University 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Ida Brenner Samuel Herskovitz 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 14017 Rippling Brook Drive, Silver Spring, MD 20906 Stephen H. Gruner (Son) 20b. Placa of Disposition (Neme of cemetary, crametory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2-22-99 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Rapp Funeral Services, P.A. 933 Gist Avenue Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immadiata Cause (Final disaasa or condition rasulting in death) MEUMONIX Examiner HOONIC OBSTRUCTIVE LUNG DISEASE Examiner physician and s the bunial-trans Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaese or injury that initiated events rasulting in death) Last that the daath certificate be axec Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 88 USB 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown signed t Aq 24b. Ware autopsy findings evaliable prior to completion of cause of daath? 24a. Was an autopsy performed? Completed paga 2 s 2 W No certificate 1 ☐ Yas 1 Yas 2 Take or Attending Physicien: funeral director, 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas / 2 No 1 Dinpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Natural death. 1 ☐ Yas 2 ☐ No 2 Accident ofter deat 6 Could not be dataminad 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Spacify) 4 Homicida Funeral F 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the causa(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and placa, and due to the cause(s) and mannar stated. 29a. Certifiar Medical (Check only To the within 2 To the 29d. Dete signed (Month, Dey, Year) 29b. Sigr 29c. License number no complated causa of death (Item 23a) (Type, Print) UP DR, OLVEY, MD 20832 32. Registrar's Signatura 1999

DHMH 16 Rev 6/95

Registrar



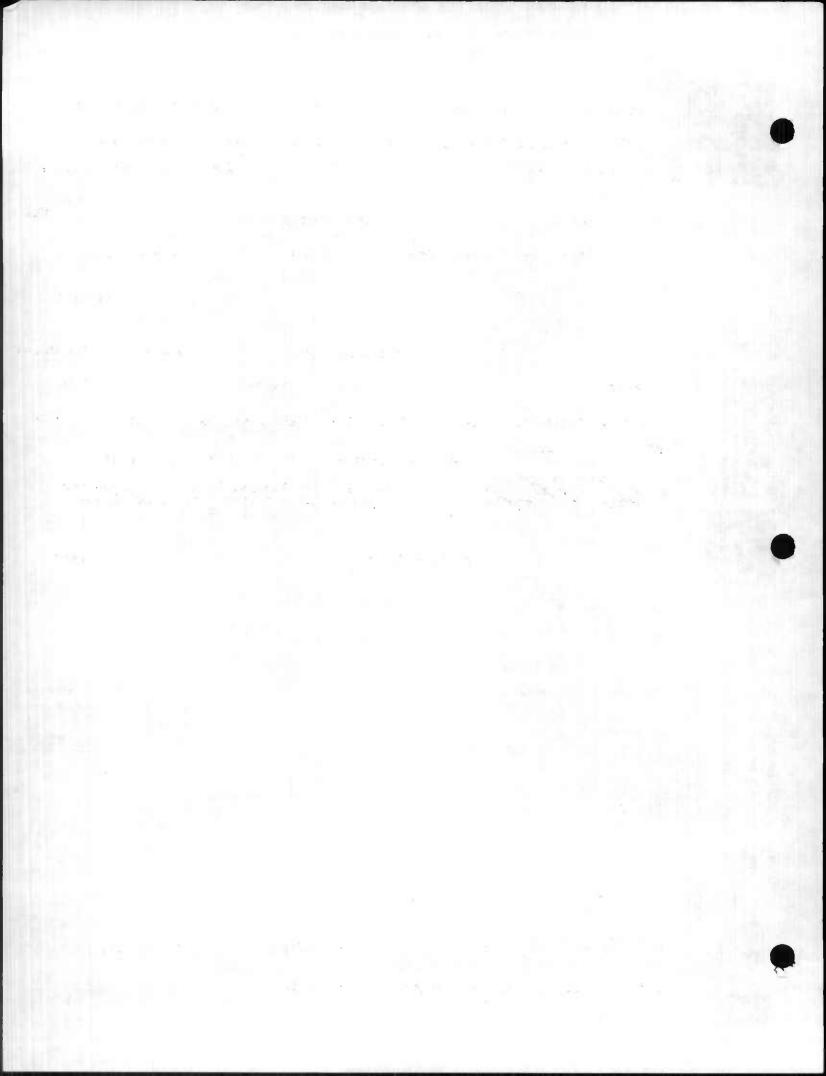
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State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** 1999 8:20PM FEBRUARY 19 GUILLETTE REGINALD AUGUSTIN /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner 606 Silver Spring Montgomery 9039 Sligo Creek Parkway, Unit # 8. Dete of Birth (Month, Day, Yeer) February 21, If Under 1 Year If Under 24 Hrs. 9. Birthpiece (Stete or Foreign 1932 Panama 7. Age (In yrs. lest birthday) 5. Sociei Security Number **Funeral** 1**X** M 2□ F Months Deys Hours 66 Yrs. Director 264-80-3649 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Example must be notified an once. 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes XXNo Directo Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Unit # 9309 Sligo Creek Parkway, 606 20901 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Marltei Stetus Bieck, White, etc. 1 Never Married 2 Married 1X Yas 2 No Specify: Panama Baltimore, Maryland 21215-0020 by Hispanic 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Eiamantary/Secondary (0-12) Panama Canal Commision Office Manager 18. Mothar's Neme (First, Middle, Maidan Sumame) 17. Fether's Neme (First, Middle, Last) Be Primus Jemima Unknown 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 1145 Southern Night Lane, Gaithersburg, Md. 20879 Ricardo A. Guillette/Nephew 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Buriai 2 Cremation 3 Removal from Stete 2/24/99 ANCON, PANAMA 4 ☐ Donation 5 ☐ Other (Specify) COROZAL CEMETERY 21. Signeture of Funeral Service Ligensee 22. Name end Address of Fecility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Md. 20904 the death. Do not antar tha mode of dying, such as cerdiac or respiratory arrast, 23a. Pert1. Enter the disease, or complications that shock, or heert failure. List only one cause on Approximata intarval Batween Onset end Deeth Physician immediete Ceuse (Finel diseese or condition resulting in death) /Medical Prostate Cancer years Examiner Due to (or es e consequenca of): Examiner and I-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or injury Due to (or es a consequence of): physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of) as 1 esn nse ŏ signed by the a 23b. Did tobacco use contribute to the causa of death? Part ii. Other significant conditions contributing to death but not resulting in the undarlying ceusa given in Pert i. 3 ☐ Probably 4 ☑ Unknown 1 Yes 2 No Š 24b. Were eutopsy findings evailable prior to completion of cause ot daeth? should 24a. Wes en eutopsy performed? Completed certificata has t 1 Yes 2 No 1 Yas 2 No Physician: director, 25. Wes cese raterred to medical exeminer? Be 26. Piece of Deeth (Check only ona) Hospitei: Other: 4 ☐ Nursing Home 5 ☑ Residance 6 ☐ Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerai 28e. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 27. Mapner of Deeth 28h Time of 28c. injury et Work? Certification: After or Attending 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No invastigation death. Director: A 2 Accidant 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicida aftar hin 24 hours after the Funeral Dire Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end dua to the ceuse(s) and manner es steted.

Medical Examinar: On the basis of examination end/or invastigation, in my opinion, daeth occurred et the time, data end place, end due to the ceuse(s) and mennar stated. 29e. Certifiar Medical (Check only one) within 2 To the Complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Janus D39190 tec February 20, 1999 0 30. Name end eddress of person who completed cause of death (Itam 23a) (Type, Print) 11510 Old Georgetown Road, Rockville, MD 20852 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State FEB 22 Registrar

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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev : 40 telo 4b. City, Town, or Location of Death Facility Name (If not institution, give street end number) 4c. County of Death PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 1□ M 2X F 578-22-8961 JULY 16, 1913 BALTIMORE, 85 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limita 1 ☐ Yes 2 X No MARYLAND CHARLES WALDORF 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? 3428 MILSTEAD COURT WALDORF UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced WHITE Yeer or Detea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SARAH ROSENFIELD HARRY KANS 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) JOSEPH F. BOBBETT, JR. - SON 14001 CELBRIDGE DRIVE, GLENWOOD, MARYLAND 21738 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c, Location - City or Town, Stete CHELTENHAM. 1 Buria P Cremetion 3 Removal from State 5 ☐ Other (Spacify) MARYLAND VETERANS CEM., FEBRUARY 25, 1999, MARYLAND 21. Signa 22. Neme end Address of Fecility THE HUNTT FUNERAL HOME, INC. Service License raun MARK G. BROHAWN M00053 P.O.BOX 156, WALDORF, MARYLAND 23a, Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Immediete Ceuse (Finel 6 MtHS. diseese or condition resulting in deeth) Sequentially list conditiona, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last B (2)000 Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 25No 3 Probably 4 Unknown HAUGITENDIM 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 9-N 250 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

the deeth certificate be executed

The law requires

Attending Physician:

Box 68760,

P.O.

Division of Vital Records.

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

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72 hours after

Baltimore, Maryland 21215-0020

Examiner the 98 USB

à Completed

icien and burial-transit Physician/Medicai signed t certificate has Be Certification: To After this we Hospital or Attendin in 24 hours after death. We Funeral Director: Aft pletely filled in by the fur

Migra	,
25. Wes case referred to medical examiner? 1 Yes 25,No	2

27. Menner of Death

1. Netural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 🗷 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basia of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner steted. (Check only one) 29b. Signeture and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29e. Certifier

mo 26 1999

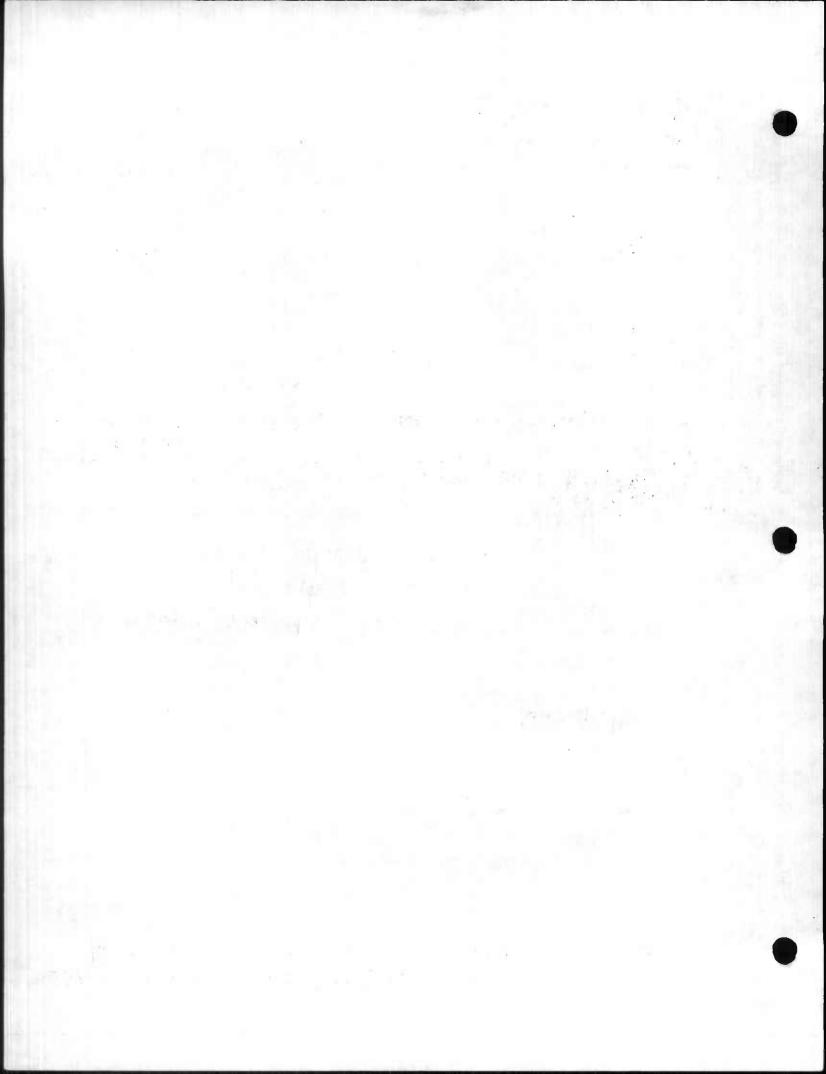
7700 32. Registrer's Signeture

State Registrar

Medicai

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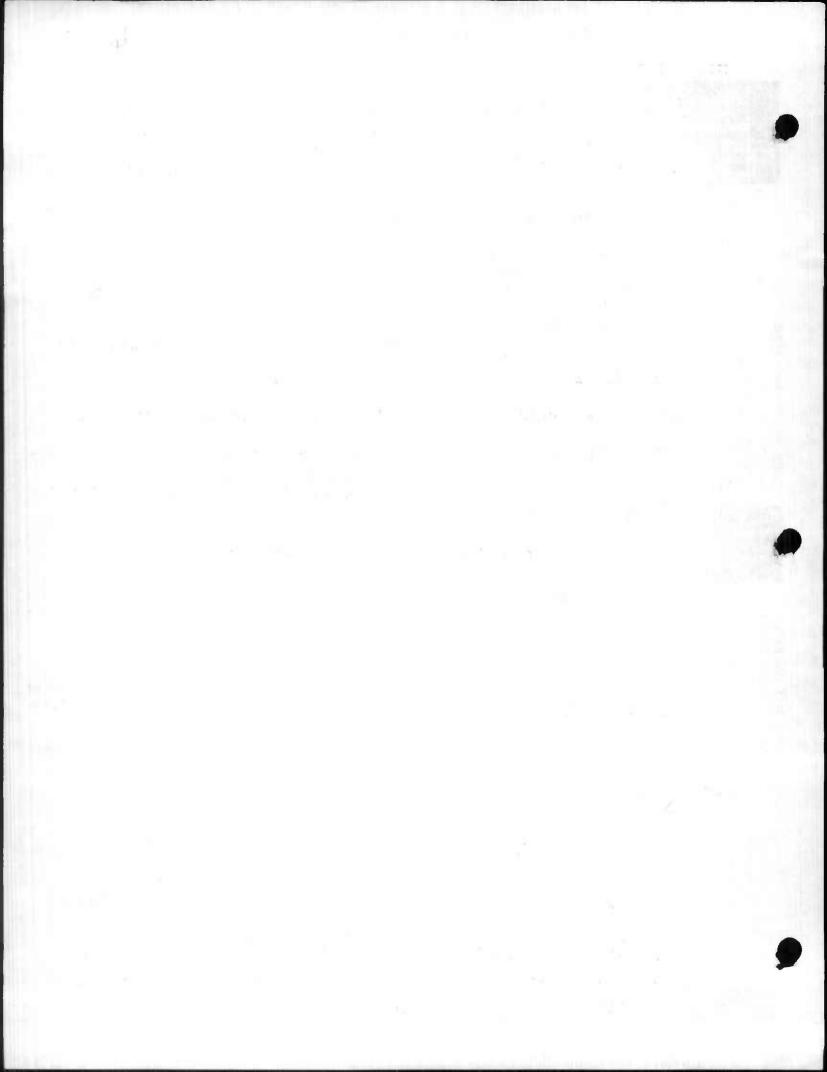
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ITEM:	: 1	#5 PER F.H. G769 3-25-99 WR	₹.	Certific	cate of L	Death		Reg. No.	1 0	1209
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aminer eral		a. Fecility Name (In not institution, give street et al. 2016). Social Security Number 6. Sex 125-58-8284	7 e Ci 7. Age (In yrs	Last birthday) H Ui 47 Yrs. Mon	A Inder 1 Year	b. City, Town, or If Under 24 Hr. Hours Mir	Burnic 8. Date of Birt	4c. County	9. Birthpleo	e (State or Foreigr rginia
NO SE		Jsual Residence of Decedent 10a. State 10b. County Marril and Anno Amundal		ity, Town or Location					10d	. Inside City Limits
Director	2	Maryland Anne Arundel		len Burnie	f. Zip Code			10g. Citizen of V	What Country	
by Funeral Director	Landia	1 Never Married 2 Married	Apt. A s Decedent Ever in the forces? Yes 2 No es, Give ar or Detes:		210 Decedent of Hi specify Cuba es 210 No		Specify Yes or No- rto Rican, etc.)		JSA e - American ck, White, etc :: Whit	
Completed	Completed	15. Decedent's Education (Specify only highest grede comp. Elementery/Secondary (0-12) Coll		16e. Decedent's I (Give kind on life. DO NO Engineer	of work done of OT use retired	furing most of we		16b. Kind of Bi	t. of	
To Be	2	7. Father's Name (First, Middle, Last) Archie C. Hall				_	ame (First, Middle, para A. D		16)	
	- 1	19a. Informant's Neme/Relationship (Type, Prir Barbara A. Brown/Moth					iural Route Numbe gerstown			-
	2	0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel 4 ☐ Donation 5 ☐ Other (Specify)	I from State	Place of Disposition cometery, crematory ational Me	or other pleci		Feb.27	Falls C	-	, State , Virgini
MINE		21. Signature of Funeral Service Licensee		22. Nam DOUG	ne and Addres	s of Facility Fiery	Funeral H	Home	Morra	l 3 217
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DHMH 16 Ray 6/95



February /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN Min. B. Data of Birth (Month, Day, Year)
JAN. 27, 1909 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1XM 2□ F Yrs. 214-09-3410 90 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or flams 23s or 28s-f show FAIRPLAY MARYLAND WASHINGTON Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 17820 SPIELMAN ROAD 21733 Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas: 1 Never Married 2 Married altimore. Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: 3 ™ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 MACHINIST AIRCRAFT MANUFACTURING 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) 8 permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is marked of EARL HUNTSBERRY MINNIE WILKINSON 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) ROBERT L. HUNTZBERRY/SON 17820 SPIELMAN ROAD, FAIRPLAY, MARYLAND 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) REST HAVEN CEMETERY 2/22/99 HAGERSTOWN, MARYLAND 21. Signature of Funeral Service Chonsee 22. Name end Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME au Boonsboro, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical Heart Examiner Ralph Henry Ventric Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last and Due to (or as a consequence of) Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1. Decedent's Nama (First, Middla, Last)

HENRY

HUNTSBERRY

RALPH

Physician

23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

 Wara autopsy findings available prior to completion of cause of death?

3. Tima of Death

4:00 Pm

Birthplaca (Stata or Foreign Country)
 MARYLAND

10d. Insida City Limits

1 Yes 2 No

WASHINGTON

U.S.A.

WHITE

21733

21713 Approximata Intarval Batween Onsat and Deeth

1 Yas 2 No

1 Yes 2 No

25. Tras casa relation to inouicat	1		26. Placa of Deal	in (Check only ona)
examiner? 1 Yas 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ DOA	Other: 4 Nursing Ho	oma 5 Rasidenca 6 Other (Specify)
27. Manner of Death 1 Driaturet 5 Pending 2 Accident invastigation	28a. Data of Injury (Month, Day Year)		Injury at Work? 1 □ Yas 2 □ No	28d. Dascribe how Injury occurred

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Data of Death

Month

Day

3 Suicida

6 ☐ Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, end due to tha causa(s) and mannar as stated.

disasse

29a. Certifier 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signatura and titla of contilior 29c. License numbe 29d. Data signed (Month, Day, Year)

30. Nama and addrass of who completed causa of death (Item 23a) (Type, Print)

BL 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

illiamsport

State Registrar

à

Completed

80

Certification: To

edical

DHMH 16 Rev 6/95

after deeth. Director: Af

or Al

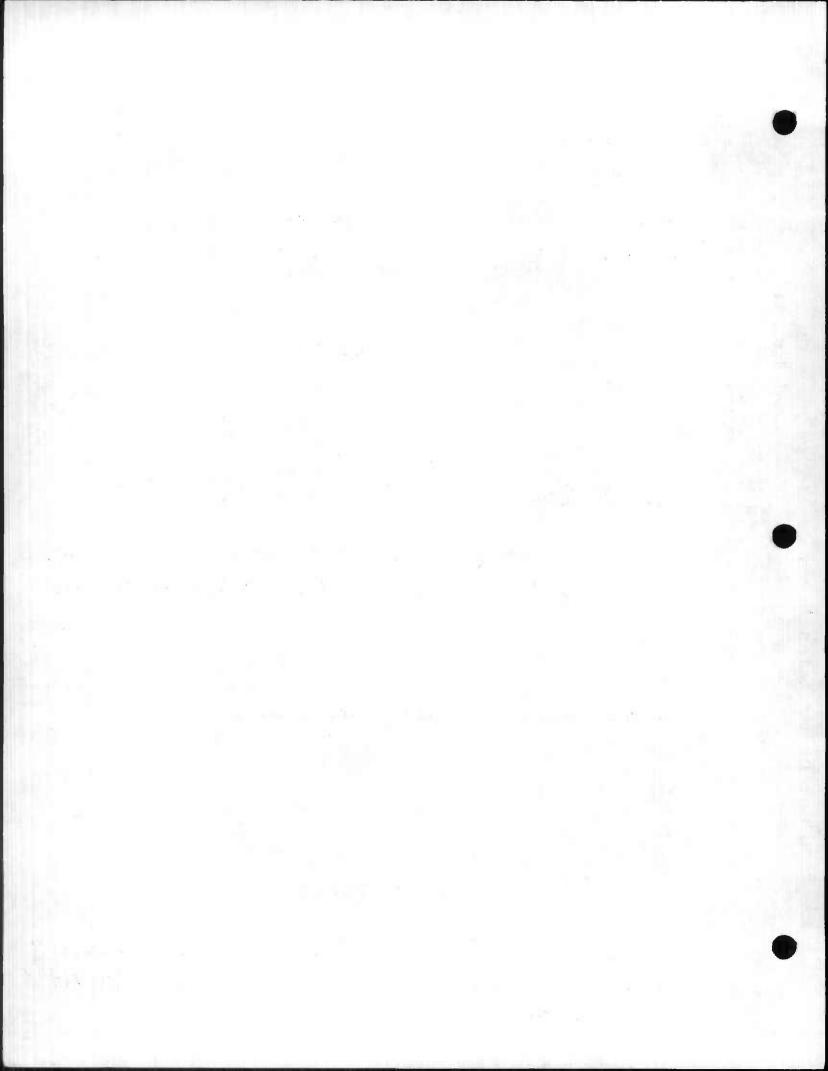
Hospital

To the within 2

a 24 hours after de Funeral Directo oletely filled in by the

Nerts berry

Division of Vital Records,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

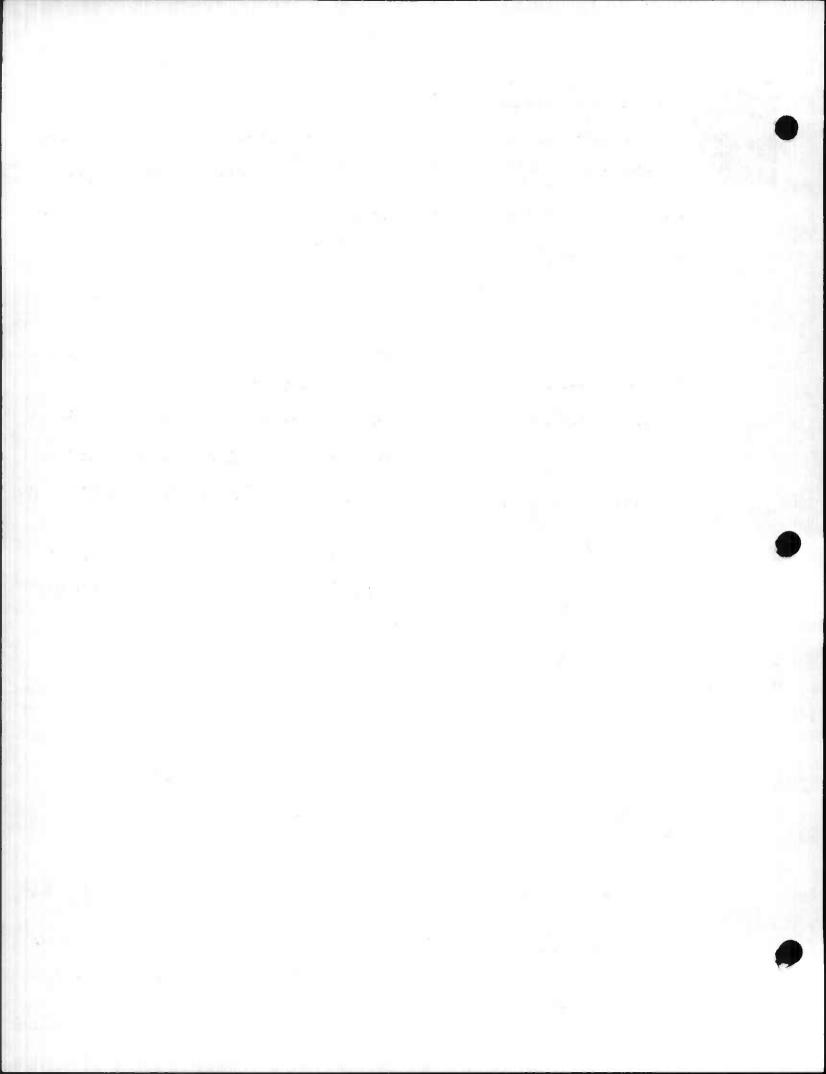
State of Maryland / Department of Health and Mental Hygiene 99 07211 Certificate of Death

Ï	Physic	ian	1. Decedent's Name	a (First, Middle, La izabeth 1				100		2. Data of D Feb. 1	8, Day 99	Year	3. Tima of Death 9:38 PM
	/Medi Exami		4a. Facility Nama (I	f not institution, giv	re street and number)				4b. City, Town, o	r Location of Dea	th 4c. Count	y of Death	n County
	Funeral Director		5. Social Security N 220–18–	umbar 6. S		a (In yrs. last bi		If Undar 1 Yaa Months Days	r If Under 24 Hr	s. 8. Data of B		9. Birthpl Coun	laca (Stata or Foreign try)
	Maryland H show	tor	Usuai Rasidance of 10a. Stata Maryland	Dacedant 10b. County Washing	ton Co.	10c. City, Tov	vn or Loca gerst						0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28a	i Director	10e. Street and Nur 610 Suns	nber et Avenue	9			10f. Zip Coda 217	40		10g. Citizan of US		try?
020	should be filed within 72 hours efter deeth with the Maryland not Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show unatic event, the Medical Exerciting must be notified at	by Funeral	11. Marital Status 1 □ Navar Marri 3 □ Widowad	ed 2 Marriad	12. Was Dacedant Armed Forcas? 1 □ Yas 2 3 If Yas, Giva Yaar or Datas:		If Y	s Decedant of as, specify Cu	Hispanic Orlgin? (ban, Maxican, Pua	Specify Yas or N rto Rican, atc.)	Bla	ce - Amarica ck, Whita, a by: Whit	atc.
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Ball	Depart Import eny in		21. Signature of Fu	neral Service Licer	Zin		22. N	lama and Addi	ass of Facility D ern Blvd	ouglas A	. Fiery	Funer n, Mar	ral Home ryland 217
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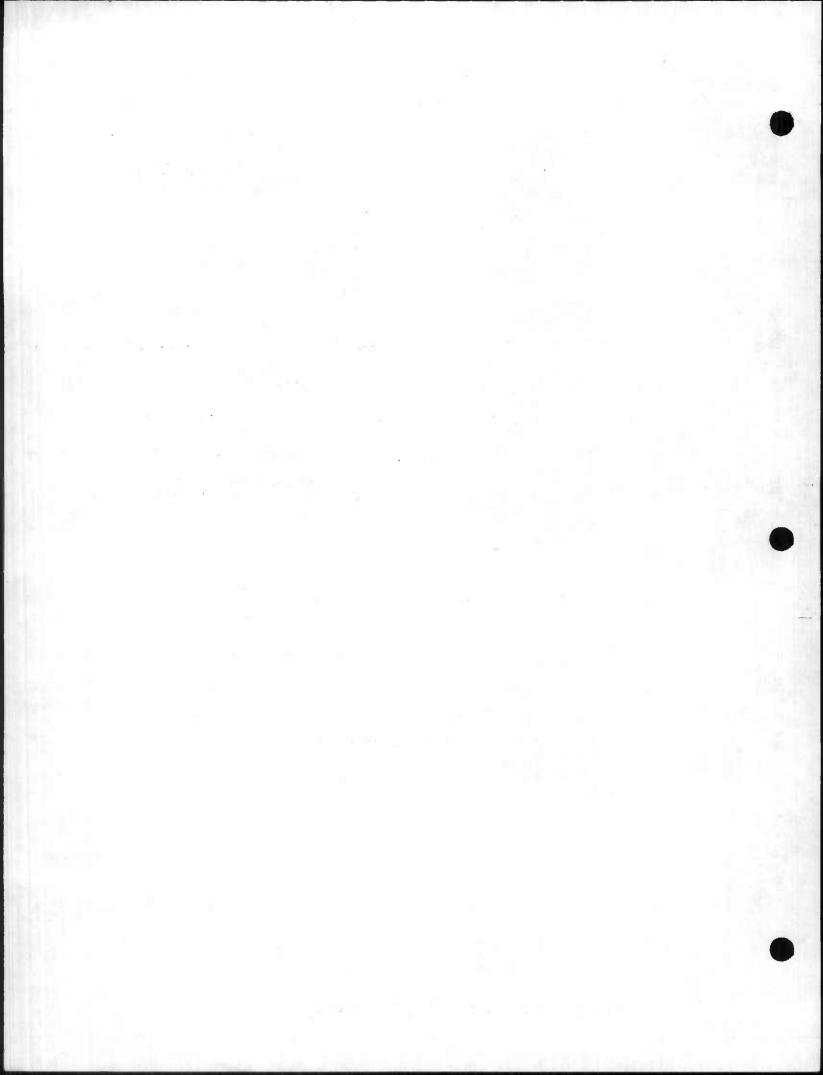
Sporks

State

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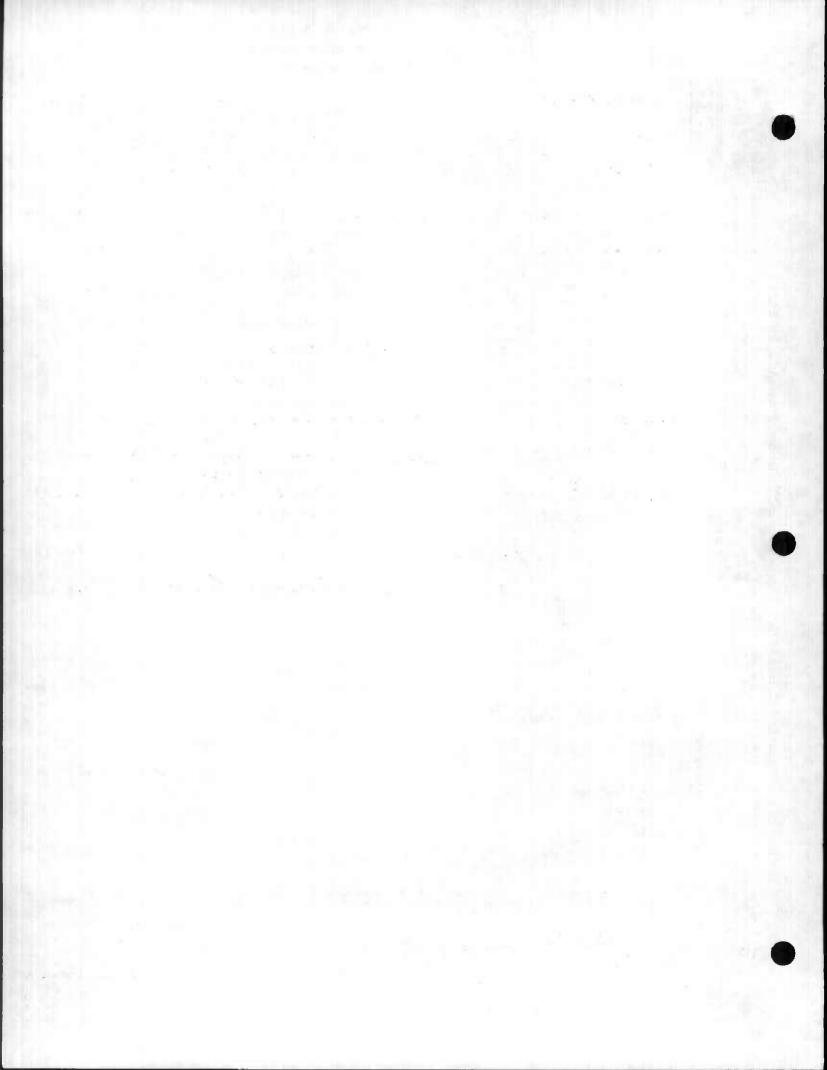
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	Examine	-	4a Facility Name (//		give street and nu ounty H		a]		4b. City, Town, or I Hagerst			of Death hing	ton
F	Funeral		5. Social Security Nu	mber	6. Sex 1√2 M 2□ F	7. Age (In yrs. 82	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	R Date of Rin		9. Birtho	place (State or Foreign
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	oth with the Marylen 23e or 28e-f show	0	Maryland	Wash	nington	H	agerst	own					Yos 2□No
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5-0	72 hc	Se l	(Specif	15. Decedent's	Education grade completed)		16a. Deced	ent's Usuel Occup	eation during most of wor	kina	16b. Kind of B	usiness/Ind	dustry
121	within than	Completed	Elementary/Secon		College (1-4or 5+)			during most of wor d)		Furnitu	re M	anufacture
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Baltimore	Pages 1 and of He mut: If Item iry or other			Cremation 3	3 □Removal from	- (cemetery, crem	sition (Name of natory or other ple	∞) al Park (Date 12-23-99	20c. Location	,	Maryland
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ita	certificate rector, pag		25. Was case referre	ed to medical					26. Place of Dea	ath (Check only o	one)		/ \
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0 0	ding Phys		27. Manner of Death	5 ☐ Pending	28a. Date		28b. Time of Injury	28c. Inju	y et rk?	28d. Describe	how injury occur	red	
Sio	Attending ir death. ector: After by the fune	200	2 Accident	investiga					Yes 2□No				
N N	tal or Attending P		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	200. Place	of Injury - At hing, etc. (Specif	ome, farm, stre fy)	et, factory, office		28f. Location (City or To	Street and Numl wn, State)	ber or Run	al Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29e. Certifier (Check only one)		caminer; On the ba				me, dete and place pinion, deeth occu				
	Withir To the comp	-	29b. Signature and ti	le of certifier		\wedge	4.	29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
			Y	27/		1	ne.p.	D	14131		3/15	0199	
			30. Name and address	a 4	ho completed caus	e of death (Iter	m 23a) (Type, I	Print) Tev	MY L.	Corre	ces,	m. I).
			21 Date filed the	8 Un	4 551	trage	rstow	n, hu	0 217	40			
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) February 22,1999 **Physician** June M. Habershon 2:45pm /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner Gaithersburg Wilson Health Care Center Montgomery If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days 1□ M 2⊠ F 80 Yrs 043-01-9208 May 6, Illinois 1918 Director Usual Rasidance of Dacedant permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantrial must be notified as page. 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Md. Montgomery Gaithersburg Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 201 Russell Ave. 20877 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 월 No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Raca - American Indian Black, Whita, atc. 11. Marital Status 1 Navar Married 2 Married Specify: White Taltimore, Maryland 21215-0020 1 Yas 2 No Specify: p 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) Executive Secretary Construction 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) John Matimore Mabel Schaiell 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Karol Ann White 215 Rabbitt Road Gaithersburg, Md. 20878 , Daughter Feb. 23, 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Alexandria, Va. 1999 Metropolitan Crematory 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility DeVol Funeral Home 21. Signatura of Funaral Sarvice Licanse 10 East Deer Park Dr. Gaithersburg, Md. 20877 Curtes 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** Immediata Causa (Final disease or condition resulting In death) /Medical Examiner Physician/Medical Examiner g physician and as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or Injury that Initiated evants Division of Vital Records, P.O. Box 68760, that initiated evants rasulting in daath) Last Dua to (or as a consequence of) attending usa Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by t þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy has cartificate ha 1□ Yas 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 25. Was cesa rafarred to madical axaminar? Be 26. Placa of Death (Chack only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 10 After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28d. Dascribe how injury occurred Certification: 28c. tnjury at Work? 1 Matural 5 Panding Invastigation daath. 1 Yas 2 No 2 Accidant eral Director: / 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarminad 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida To the Hospital within 24 hours a To the Funeral Complataly filled 1 Certifying Phyalcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edical 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and tilling certifian 1733357 22/35 30. Nama and addrass of person who complated causa of plaath (Itam 23a) (Type, Print) 5530 Wisconsin Are 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State **FEB 24** Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey **Physician** WILLIAM HARRIS 22, 1999 4c. County of Death FEBRUARY 9:30PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner ROCKVILLE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) HEBREW HOME OF GREATER WASHINGTON MONTGOMERY If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** M 2□ F Months Days 167 07 9799 90 Yrs. **Director** JUNE 1, 1908 PENNSYLVANIA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes & No MARYLAND MONTGOMERY BETHESDA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours aftar death with 1 Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 2 and highry or other traumatic avent, the Medical Examination once. 20814 5225 POOKS HILL ROAD # 205W IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ø No Specify: Specify: by WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) MUSICIAN VIOLINIST 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be SAMUEL HARRIS CLARA UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JUDITH MONSEIN /DAUGHTER 7105 ARRAN PLACE BETHESDA, MARYLAND 20817 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date XXBurial 2 Cremetion 3 Removal from State 4 □ Donation 5 □ Other (Specify) KING DAVID MEMORIAL GDNS 2/24/99 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Sawice Licensee 22. Name end Address of Facility DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 23a Part1 Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near) failure. List only one cause on each line. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 Approximate Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical CARCINOMA OF PROSTATE MENTHS & METASTATIC Examiner Due to (or as a consequence of) Examiner physician and the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) 87 esn ò signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yee 22 No 3 Probably 4 Unknown ARTERY DISEASE by Records, 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of ceuse of death? certificata has b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical examiner? Be 28. Piece of Deeth (Check only one) To Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No or 24 hours after deat. Fundamental Director: A staly filled in by the first death. investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 172 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Dey, Year) FEB 25 1999

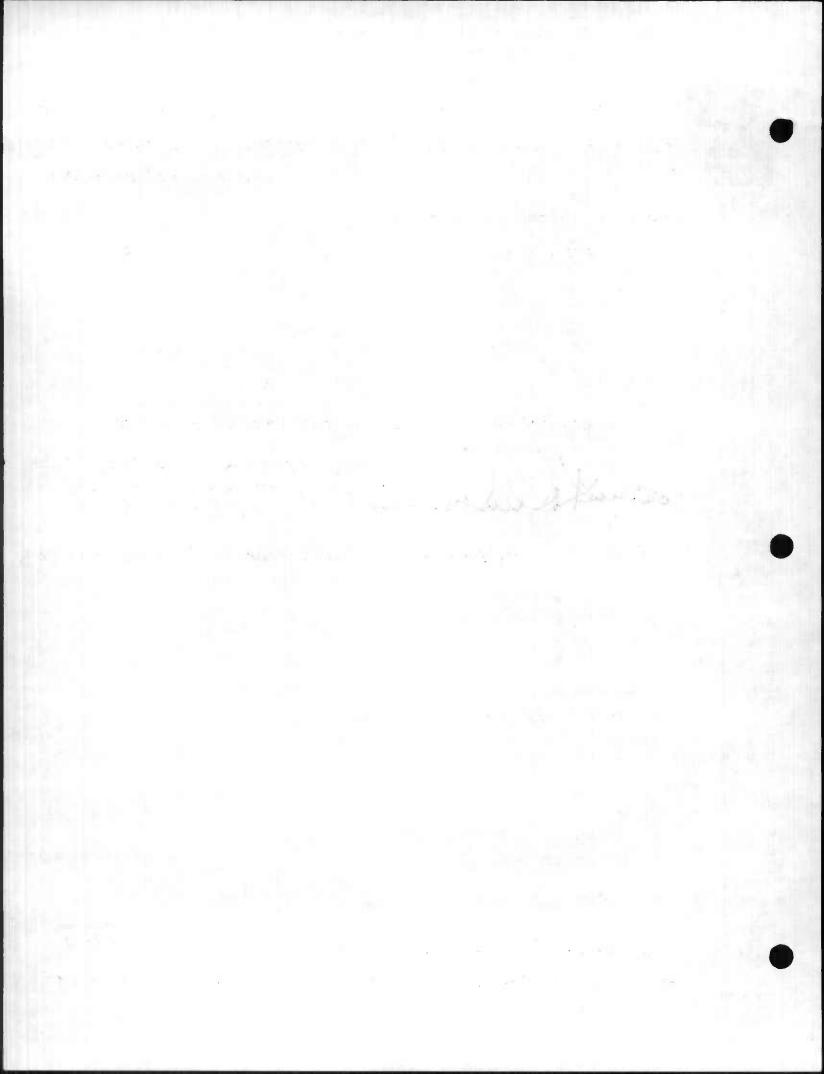
1P 50 N 6/2-1 32. Registrar's Signature 6.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONTROSE Spark

05885

LD, LOCKVILLE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 23, 1999 William Edward Harrison February 3:24 PM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva straat and number) Maplewood Park Place Bethesda Montgomery If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Months Days Hours Min. 180 M 2□ F Yrs. 90 Jan. 9, 1909 Kentucky 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2X No Montgomery Bethesda 10f. Zip Coda 10g. Citizen of What Country? 9707 Old Georgetown Road #114 20814 United States 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. K Yas 2 No 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: If Yas, Giva Yaar or Datas:<u>1942–1952</u> 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Civil Engineer Public Corporation 17 Fathar's Nama (First, Middla, Last) 18 Mothar's Nama (First, Middle, Maidan Sumama) Charles Lewis Harrison Ida Klotzbach 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 9707 Old Georgetown Rd., #114, Bethesda, MD 20814 Janet K. Harrison/Wife 20b. Place of Disposition (Nama of camatary, cramatory or othar place) February 25, 1999 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Parti. Enter the dimeasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast,

Approximate Approximata Intarvat Batween Onsat and Death Aspiration Pneumonia 3 days Dua to (or as a consequance of): Cerebrovascular Accident 4 days Dua to (or as a consaquanca of): Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy 1 ☐ Yes 2 NO No 1 Yas 2 No

Physician /Medical Examine

physician and the burial-transit

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Hospital or Attanding Physician: 24 hours after daath. Funeral Director: After this cartifica staly filled in by the funeral director, I

To the Hospital or A within 24 hours after To the Funeral Direcompletally filled in b

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law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

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Completed

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Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or

permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic avent, the Medical Examiner manal page.

Baltimore, Maryland 21215-0020

with the Maryland r 28a-f show 5. Social Sacurity Number

275-26-8417

10e. Street and Number

10a Stata

Maryland

11 Marital Status

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Usual Rasidanca of Decedant

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Immediata Causa (Final disaasa or condition rasulting in daath)

20a. Mathod of Disposition

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was casa rafarred to medicat axaminar? 1 Yes 2 No 27. Mannar of Daath

Othar: 4™ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work?

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1 Naturat 5 Panding invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 4 Homicida

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Location (Street and Number or Rural Routa Number, City or Town, Stata)

file of cegif 29b. Signature a

29a. Cartifiar

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29d. Data signed (Month. Dav. Year) 29c. Licansa number

26. Placa of Death (Chack only ona)

30. Nama and addrass of parson who completed causa of death (Itam 23a) (Type, Print)

February 24, 1999

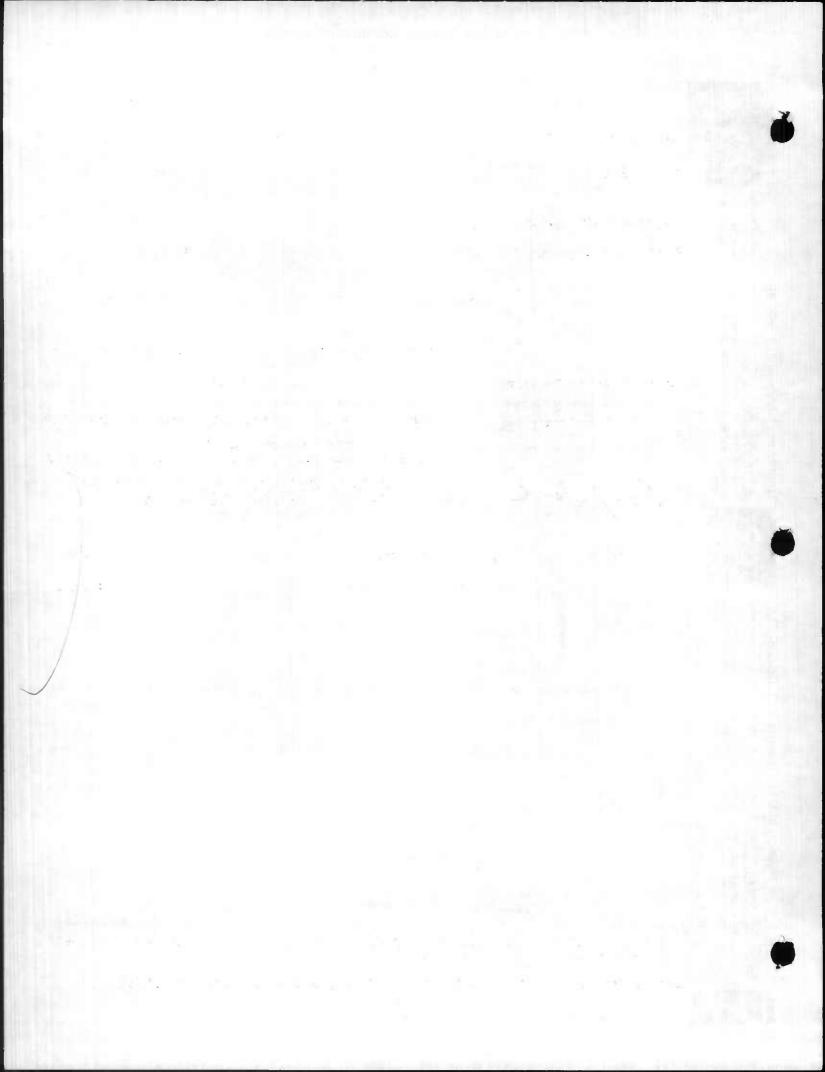
5602 Shields Drive, Bethesda, Maryland Lee R. Pennington, M.D. 31. Data filed (Month, Day, Year)

State Registrar

FEB 26



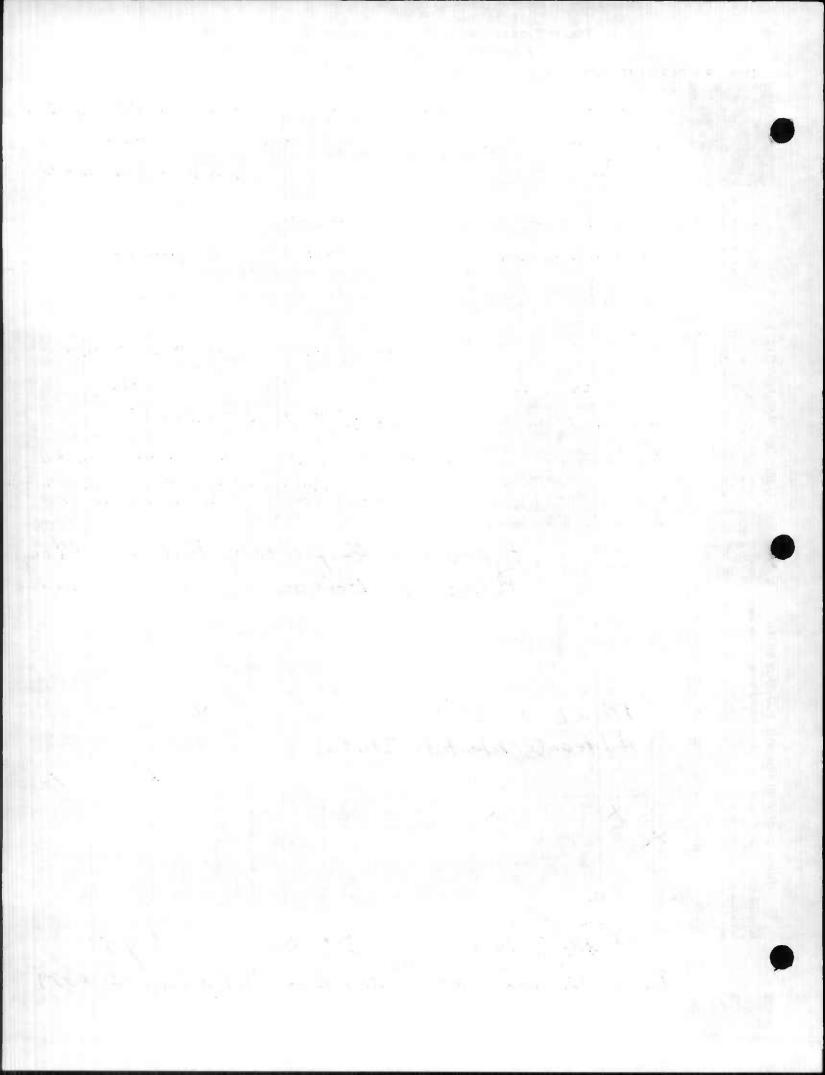




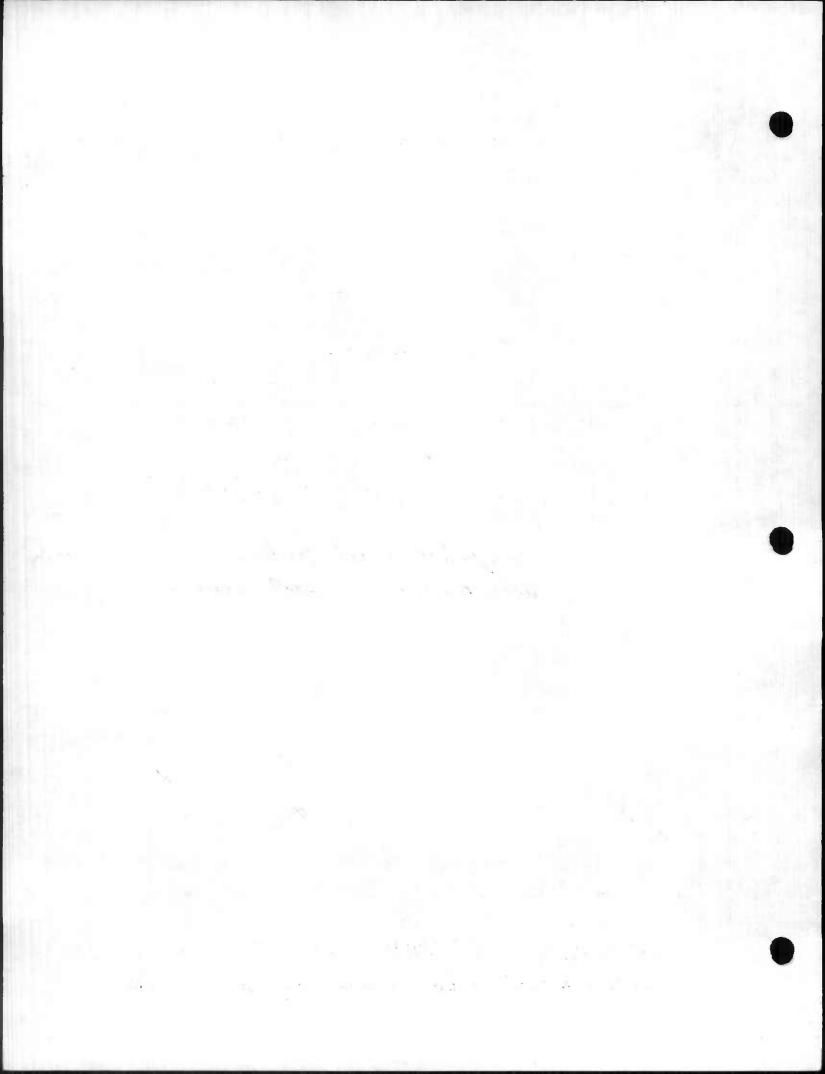
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 07216

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	Certificate of Death	Reg. N	
Physician	1. Decedent's Neme (First, Middle, Last)		ay Year 3. Time of Death
/Medical	Mildred S. mart		21, 1999 10:20 AM
Examiner		n, or Location of Deeth	c. County of Death
	Potomac Valley Nursing and Wellness Ctr. Rockvi	31	Montgomery
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 2.2.3 — 0.5 — 1.0 / .2 I M 2 G F 86 Yrs. Months Days Hours	Min. 8. Date of Birth (Month, Day, Year Sept. 29,	9. Birthplaca (Stete or Foreign Country)
Director	223-03-1042	Sept. 29,	1912 Virginia
pu a	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
aho aho			1 ☐ Yes 2 No
New Age of	VA Fairfax Great Falls	10-0	
E 0 8 C	10e. Street and Number	10g, C	itizen of What Country?
death with the Maryland ime 23e or 28e-f ahow mult be notified at marsi Director	9103 Weant Drive 22066		USA
urs after	3 ☐ Widowed 4 □ Divorced If Yes, Give Yeer or Dates:	ny (Specify Yes or No- Puerlo Rican, etc.)	14. Rece - American Indian, Black, White, etc. Specify: White
natural',	15. Decedent's Education 16a. Decedent's Usual Occupetion (Specify only highest grade completed) (Give kind of work done during most of	16b. I	Kind of Business/Industry
- 2	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+)		
yeight of	12 Bookkeeper		Retail
doth and H	17. Fether's Nama (First, Middle, Last) 18. Mother's	s Name (First, Middle, Maide	
Men Hickory		essie Dickers	son
permit. Peges 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than any injury or other traumatic avent, 1 a. M. DDCs.	19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number of Street and Number of	or Rural Route Number, City	or Town, Stete, Zip Code)
and and n 27	Elizabeth Huebner/Friend 9103 Weant Dr., Gre	at Falls, VA	22066
of Hear	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	Dete 20c. t	Location - City or Town, Stata
Peg nent int: h	4 Donetion 5 Other (Specify) Arlington National Cem.	3/1/99 Ar1	Lington, VA
permit. Peges 1 a Department of Hea Important: If Nem any Injury or othe once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility		llins Funeral Home
28558	Inc. 500 Univers	sity Blvd. Wes	st
	Silver Spring, MI 23a. Part1. Anter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as ca		Approximete
Physician /Medical Examiner	shock, of heart tailure. List only one cause on each lina. Immediate Cause (Finel disease or condition resulting in death) a. Congustive heart fault for as a consequence of): - Alleron duration to the consequence of the	lung	Intervel Between Onset and Death
at the death certificate be assocuted by the attending physician and etached for use as the burial-transit Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disees or Injury thet initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	T dueas	
the attending the for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacc	co use contribute to the cause of death'
that the de ed by the detached		1 ☐ Yes	No 3 Probably 4 Unknow
been sign should be		24a. Wes en autoperformed?	opsy 24b. Were autopsy tindings available prior to completion of cause of death?
certificate has lirector, page 2		1 ☐ Yes	20 No 1 □ Yes 2 □ No
certificate rector, pag		Deeth (Check only one)	
Physician: this certifical director,	1 Tyes 20 No Hospital: 1 Innatiant 2 FR/Outpatient 3 DOA Other: DA Nurs	ing Home 5 ☐ Residence	6 DOther (Specify)
Physer this eral dia		28d. Describe how inj	
tal or Attending P rs after death. al Director: After led in by the funers Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 1 Yes 2 No.		and Number or Rurel Route Number, te)
he Hospi in 24 hou he Funer pletely fill edical	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and company stated and menant stated. 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death and menant stated.	occurred at the time, date an	nd place, and due to the cause(s)
To the Com	29b. Signature and substraction 29c. License number	29d. D	Pate signed (Month, Day, Year)
10	CONTRACTOR DOILZ	-O Febr	cuary 22, 1999
1	30. Name and address of person who completed cause of death (Usm 23a) (Type, Print)	122	
	Walter E. Goozh, M.D. 1299 Lamberton Drive, Silver	Spring, MD	20902
		ppi ing, im	20702
State	31. Date filed (Month, Dey, Year) 32. Registrer's Signeture 4. Locals		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month 12:30 AM Mary Gilhooley Higgins February 24, 1999 4a Facility Name (If not Institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 30, 19 If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foraign Country) Days 1□M 21 F Months Yrs. 89 578-05-5973 1909 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☒ No Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 915 Snure Road 20901 USA 14. Race - American Indian, 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mothar's Nama (First, Middle, Meiden Sumeme) 17. Father's Nama (First, Middla, Last) Margaret Vaughn Patrick A. Gilhooley 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 915 Snure Road, Silver Spring, MD 20901 Mary Patricia Higgins 20b. Place of Disposition (Neme of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State Gate of Heaven Cemetery 2/27/99 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral 21. Signalum of Funaral Service Licensee 500 University Blvd. West Home, Inc. wou Silver Spring, MD 20901 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Causa (Final a assuration Preumonetis disaase or conditio rasulting in death) Due to (or as a consequence of): b. Parpuners Disease Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Diseasa or Injury that initiated avents resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed' 2 1 No 1 Yes 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one)

Physician /Medicai **Examiner** certificata be axecuted

Physician

· /Medical

Examiner

Director

Funeral

by

Completed

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examiner must be notified at

permit. Pages 1 and 2 should be flied within 72 hours effer to Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Mexical Exprised page.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

or Attending Physician:

Hospital

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Examiner 88 esn ö director,

physicien end s the burial-trens the signed by th page 2 s certificate After this funeral

Physician/Medical P Completed Be P Certification:

after death. A 24 hou.

To the Hosp within 24 ho To the Fune completely f 0

25. Was casa referred to medicel examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1.2 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - Al home, farm, streef, factory, office building, atc. (Specify) 4 Homicide

29a. Certifier Le Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and placa, and dua to the cause(s) and mannar as stated (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. Licanse number

Benord a Heckman, M.D.

005373

2/24/99

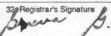
30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)

8830 Cameron Street, Silver Spring, MD Bernard A. Heckman, M.D.

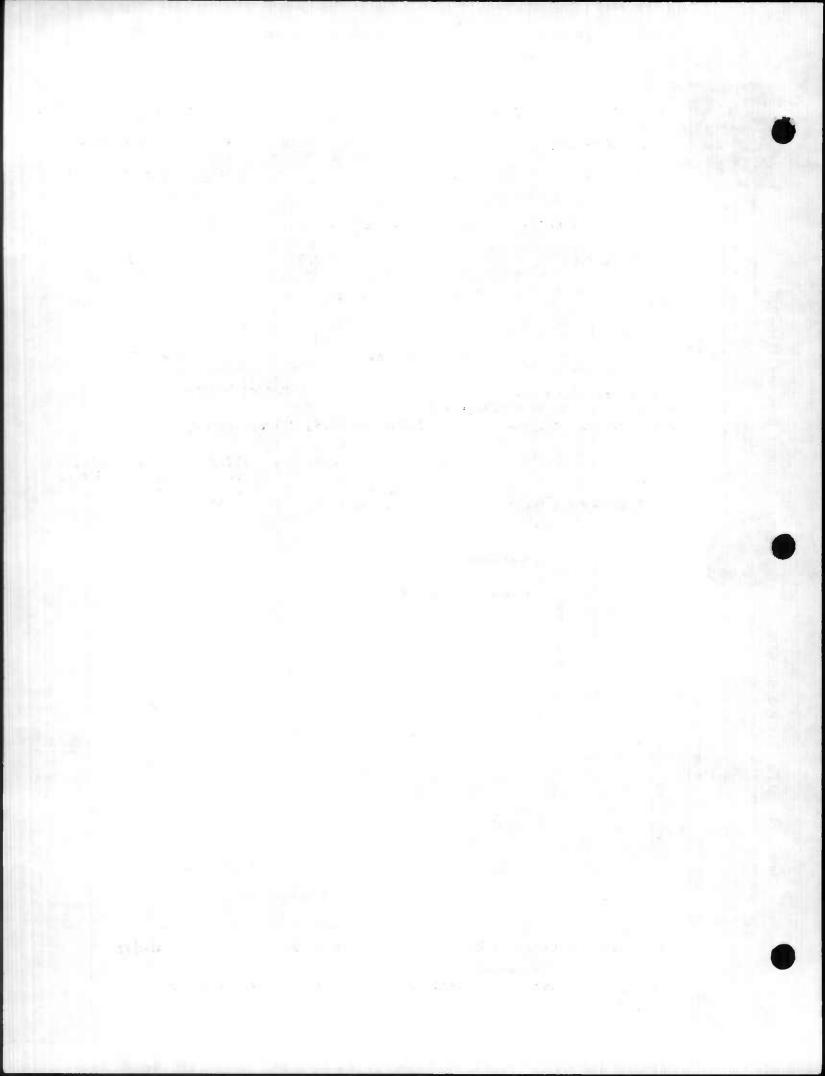
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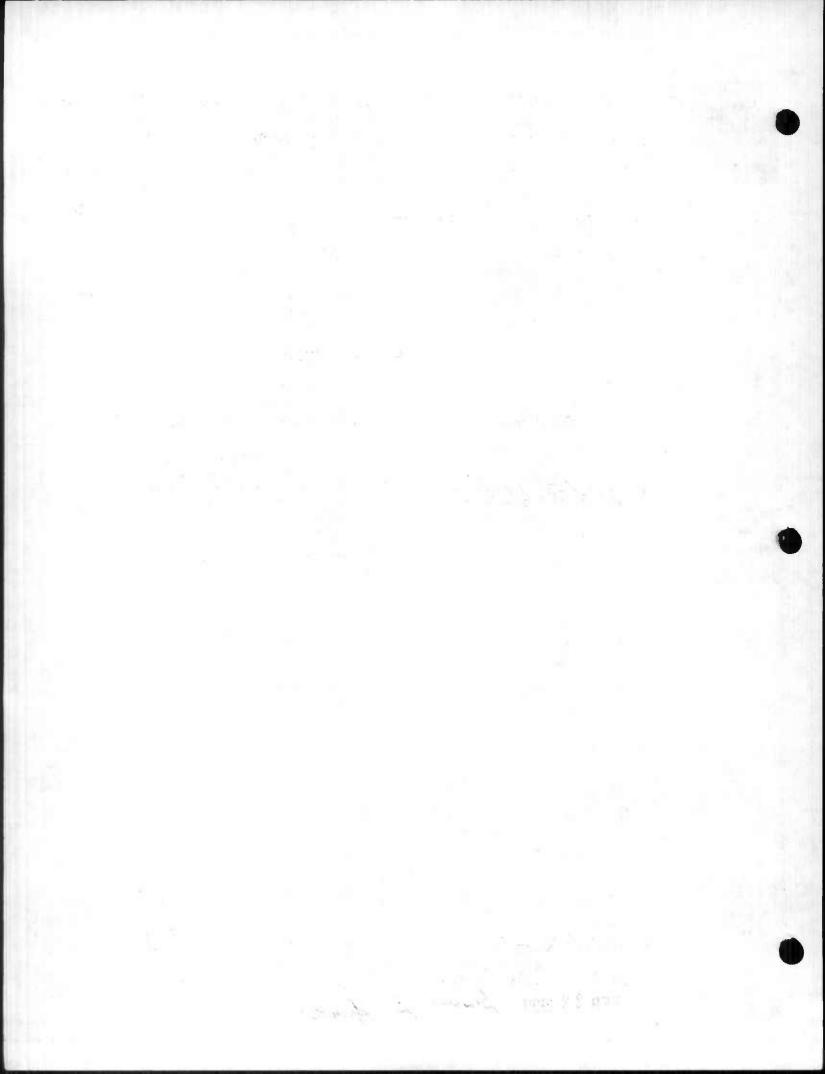






State of Maryland / Department of Health and Mental Hygiene

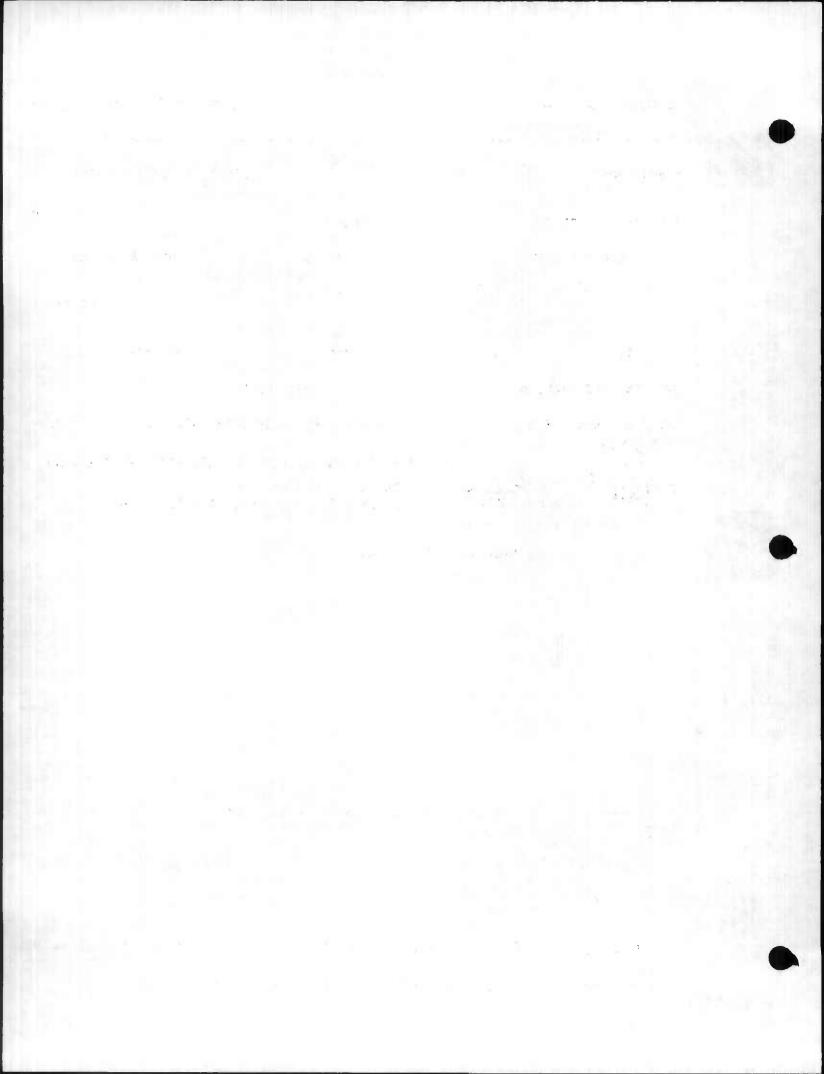
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/Med Exam		de Centile hierer det een teeth eter				4	4b. City, Town, or CHESTE	Location of Deeth	4c. Count	The second second	1000
Funera Directo	_	052-32-4778	Sex 7. Ag	e (In yrs. last birth	day) If Un Month	der 1 Year ns Days	If Under 24 Hr. Hours Mir		1938	9. Birthp Court Hick	elece (State or Foreign stry) sville, N
/land		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town	or Location					1	0d. Inside City Limi
e Man	ctor	Maryland Kent		Cheste	rtown						1 ☐ Yes 2 ☐ N
a or 2	Director				10f.	Zip Code 2162	10		10g. Citizen of USA	Whet Coun	ntry?
filed within 72 hours after death with the Maryland thygiene. ther then "natural", or items 23e or 28e-f show int, the Medical Examiner must be political at	by Funeral	11. Meritel Status 1 □ Never Married 2 ☒ Married	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Yeer or Detes:					Specify Yes or No- rto Ricen, etc.)	14. Re	ck, White,	etc.
filed within 72 hours aft Hygiene. other than "natural", or ent, the Wed cal Exp. it	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondery (0-12)	ducation ede completed) College (1-4or !	5+)		work done of use retired	etion during most of wo	orking	16b. Kind of B		dustry
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Department of Haaith Important: if Itam 27 any Injury or other transcent		20a. Method of Disposition		20b. Piece of D		Verne of		Date			
Page nent o		1 X Burial 2 ☐ Cremation 3 [4 ☐ Donetion 5 ☐ Other (Speci		Rocky Ga				2/23/99	Rocky Gar	o, MD	
auth certificata be executed attending physician end for usa as the buriel-trensit	edicai Examiner	Ceuse (Disease or Injury thet initieted events resulting In death) Lest	e. Adouo (nsequence o	Cung on:		h Augitis			Onset end Deeth
0 0	Physician/M	Part II. Other significant conditions	contributing to death b	ut not resulting in t	he underlyin	g ceuse give	en In Pert I.	23b. Did to	obacco use co	ontributa to	the cause of dea
that the ed by detac								URTY	'ss 2□ No	3 ☐ Prot	pebly 4 Unkn
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ysician: T is certificat director, p	BeC	25. Wes case referred to medical exeminer?					26. Plece of De	eth (Check only or	`	1	Tes ZLINO
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or Atta efter der Director i in by th	Certification:	3 Suicide 6 Could not be determined		Iry - At home, farm :. (Specify)	, street, fact	ory, office		28f. Location (S City or Town	treet end Numi n, Stete)	ber or Rure	l Route Number,
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To the Hospital or Attending F within 24 hours effer deeth. To the Funeral Director: After completely filled in by the funer	⊗ Medio	29b. Signeture and title of certifier	De000	g	2	D So	number 0996	2	9d. Date signe		Dey, Year)



State of Maryland / Department of Health and Mental Hygiene

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				Ce	rtificat	e of	Death		Reg. N	lo.			
Physician	1. Decedent's Name (First, Midd							2. Date of Month		ax .	Year	3. Time of Deeth	
/Medical	EUGENE ALAN											1:30PM	
Examiner	2183 BRIARWO	OOD DRIVI					W	ALDORF	CHARLES				
Funeral Director	5. Social Security Number 579–40–9039	6. Sex X 1	7. Age (In yrs. 68	last birthday) Yrs.	If Under Months	1 Year Deys	If Under Hours	Min. 8. Date of (Month, APRIL	Birth Day, Yea 17,	⁷⁾ 1931	9. Birthpl Count VIRG	lace (State or Foreign try) INIA	
P Ku	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Le	ocation						10	Od. Inside City Limits	
or 28a-f show be notified at Director	MARYLAND CHARI 10a. Street and Number	LES			WAI	DOR.	F		10g C	itizen of \	What Count	1 ☐ Yes 2 📉 No	
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ed within 72 hours al ypiens, er than "natural", or 4, the Medical Exam Completed by 1	15. Decader (Specify only higher Elementery/Secondary (0-12)	nt's Education st grade completed) College (College (1-4or 5+)		6e. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire		ation during mos d)	st of working	16b.	Kind of B	ualness/Ind	ustry	
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Be seeme	17. Father's Neme (First, Middle,							er's Name (First, Mid	ate, Meide	n Sumen	10)		
To To	MELVIN YOUNG HA			1				GREY					
12 sh h and hare reaum	19a. Informant's Name/Relations							per or Rural Route Nu					
김 집 아 노	KEVIN M. HALL -	- SON	20h E	8511 Place of Dispo			AD, C	HARLOTTE I	7		YLAND City or Tox		
Page ment of ant: If I	20a. Method of Disposition 1 Buylar 2 Cremation 4 Donation 5 Other (S	3 □Removal from Specify)	State	emetery, cre	matory or o	ther plac		EBRUARY 2				RF, MD	
Demit Depart Import Imp	21. Signal union Furieral Service	Stokan	0053	TH		ITT :	FUNER	AL HOME,		D 2	0604		
	MARK G. BROHAWN M00053 P.O.BOX 156, WALDORF, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.										20604 Approximate Intervel Between		
Physician	Shock, of heart failure. List	only one cause on e	ech ine.								†	Onset and Death	
/Medical	Immediate Cause (Final disease or condition	PANO	CREATI	C CAN	CER							YR	
Examiner	resulting in death)	a	Due to (c	or as a conse	quenca of):				18				
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tificate be executed g physician and as the bunal-transit										İ	1 33		
certificate be executed ding physician and se as the buriat-transit	that initiated events resulting in death) Last	С	Due to (o	r as a consec	quence of):								
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Physician: The Irbis certificate harral director, page: To Be Com	25. Was case referred to medica	ıl					26. Plec	e of Death (Check or	lly one)				
2 00	examiner?	Hospital: 1 🗆	Inpatient 2	ER/Outpatie	nt 3 DC	Oth Oth	er: 4 N	ursing Home XX R	esidence	6 Oth	er (Specify	1)	
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tal or Attending P is after death. al Director: After ted in by the funers Certification:	3 Suicide 6 Could 4 HomicIde determ	not be nined 28e. Place buildi	of Injury - At hing, etc. (Specif	ome, farm, st	reet, factor	, office			28f. Location (Street and Number or Rural Route City or Town, State)		I Route Number,		
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one) 2 Medical	Examiner: On the b	best of my kno asis of examina ner stated.	wledge, deat tion and/or in	h occurred vestigation	at the tir , in my o	ne, date ar pinion, dea	nd placa, end due to ath occurred at the tire	the cause ne, date e	(s) and mand many not place,	anner as st and due to	ated. the cause(s)	
vithin To the compl	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon									d (Month, I	Day, Year)		
->-0	1 Koup	- Y.	TEN	020\7		283	52		FE	BRU	ARY 2	22, 1999	
	30. Name and eddress of person KRISHAN MATH					т.:	A DT	ATA MD	206	46			
State	31. Date filed (Month, Day, Year,	32. F	legistrer's Signa		. 147	, 111	r PLI	MIN, PID	200	70			
State Registrar	FFR 2	6 1999	boner		. 16	oor	Ka/						



State of Maryland / Department of Health and Mental Hygiene Q Q 07221

FEBRUARY 26, 1999

					Cei	rtificate	e of	Death			Reg. No.		16.6.1		
ysician	1. Decedent's Neme									2. Dete of De	eth Dey	Yeer	3. Time of Death		
cian Iical	JOHN JO	SEPH HA	RVEY							FEBRUA	-	1999	15:45 PM		
iner	4e Fecility Neme (If	not Institution, giv	e street and nu	mber)				4b. City, To	wn, or Lo	cation of Deet	h 4c. Count	y of Deeth			
	MEMORIAL	HOSPITAL					C	CUMBER			ALLI	EGANY			
at	5. Social Security No			7. Age (In yrs.		If Under Months	1 Yeer Devs	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ty, Yeer)	9. Birthp	place (Stete or Foreign ntry)		
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	10a. Stete	10b. County		10c. Cr	10c. City, Town or Location CUMBERLAND						10d. Inside City L				
Director	MARYLAND	ALLEGA	NY		COWRER	KLAND					1 X Yes 2 ☐ No				
5	10e. Street end Num	nber				10f. Zip	Code	Code			10g. Citizen of	Whet Cour	ntry?		
ă	503 WILL	LIAMS STR	EET	2			21502				U.S.	Α.			
runerai	11. Marital Status		12. Wes Dec	Decedent Ever In U,S. 13. Was Decedent of Forces? 13. Was Decedent if Yes, specify				Hispanic Or	igin? (Spe	ecify Yes or No	- 14. Ra	ca - Americ			
	1 Never Merrie	ed 20 Merried		2 ☐ No ive						nican, etc.)		ck, Whita,			
	3 Widowed	4 Divorced	If Yes, G Year or E	ive Deles: WW1]		1 Yes 2	No.	Specify:			Speci	fy: Wi	HITE		
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	21. Signature of Fur	neral Service Licer	Ace o	100	22	2. Name and	d Addre	ess of Fecili	ity						
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2	29b. Signature and	the of certifier	1			290	. Licen	se number			29d. Date sign	ed (Month,	Dey, Year)		

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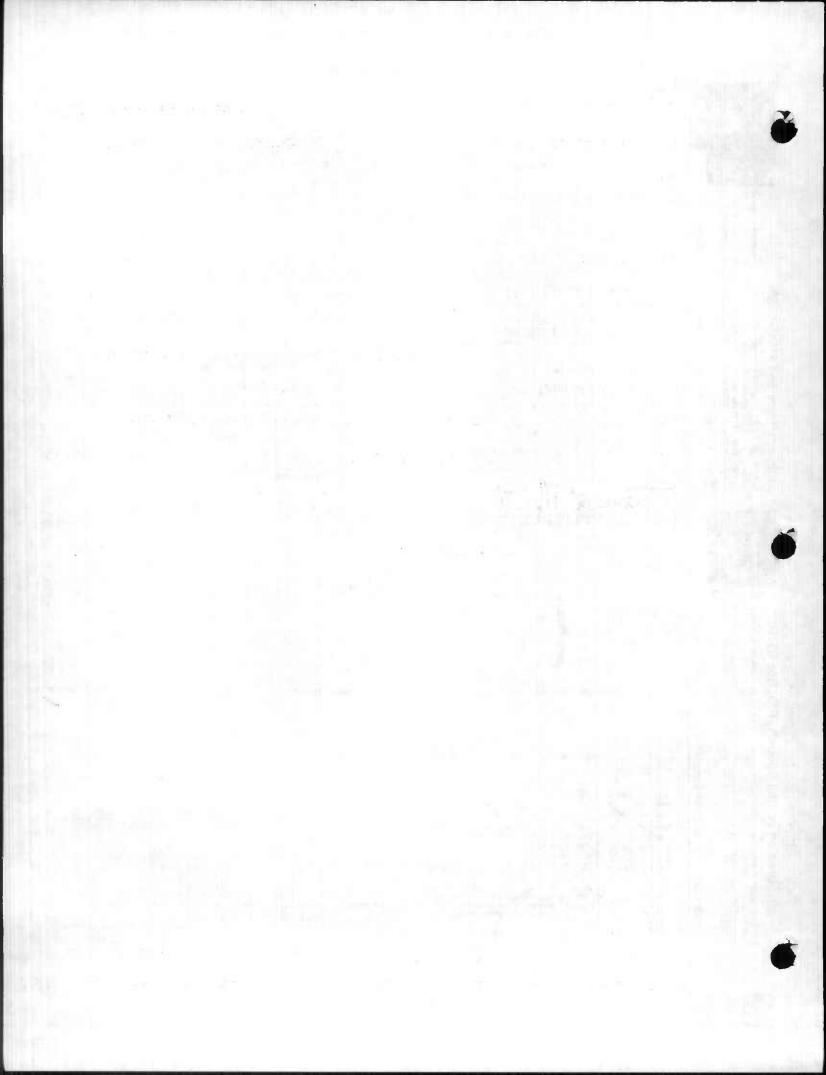
W. GUY FISCUS, MEMORIAL MEDICAL BUILDING, 500 MEMORIAL AVE., CUMBERLAND, MD

30. Name and address of person who completed dust of death (Item 23a) (Type, Print)

31. Dete filed (Month, Dey, Year) FEB 2 6 1999

32. Registrer's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEB 21, MARGARET VIRGINIA HARDMAN 3:12 P.M. /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 564 A STREET LAVALE ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 22, 1909 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** 10M 2XF Days Hours 89 214-05-4387 Yrs. Director Usuai Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits Peges 1 and 2 should be filed within 72 hours effer death with the Marylar neatt of Health and Mental Hygiene, and the file man 23s or 28s-1 show that if them 27 is marked other than "natural", or items 23s or 28s-1 show ury or other traumatic event, its had call that item from the next and ury or other traumatic event, its had call that item from the contract. LaVale 1 Yes 2 □ No Director Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 564 A Street USA 21502 Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 3 Widowed 4 □ Divorced Specify white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cumberland Cloak retired 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Washington Mary Brag 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Wolfe 11025 Highland Estates Dr; Cumberland, MD 21502 20b. Placa of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Pegas Department of Important: If It any Injury or o 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Burial Park 02/24 Cumberland, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502 ames 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate fnterval Between Onset and Death **Physician** /Medical Immediete Ceuse (Final unknown yr ARTERIOSCLEROTIC HEART DISEASE disease or condition resulting in death) Examine Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted ician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): 88 950 been signed by the atte should be datached for Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy performed? completion of cause of deeth? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examinerr 1⊠ Yes 2□ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Division Naturai 5 Pending s after deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours a
To the Funeral D
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feb. 21, 1999 D09157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nus Paul Snow, Depty Med Ex; 124 W Third St; Cumberland, MD 21502

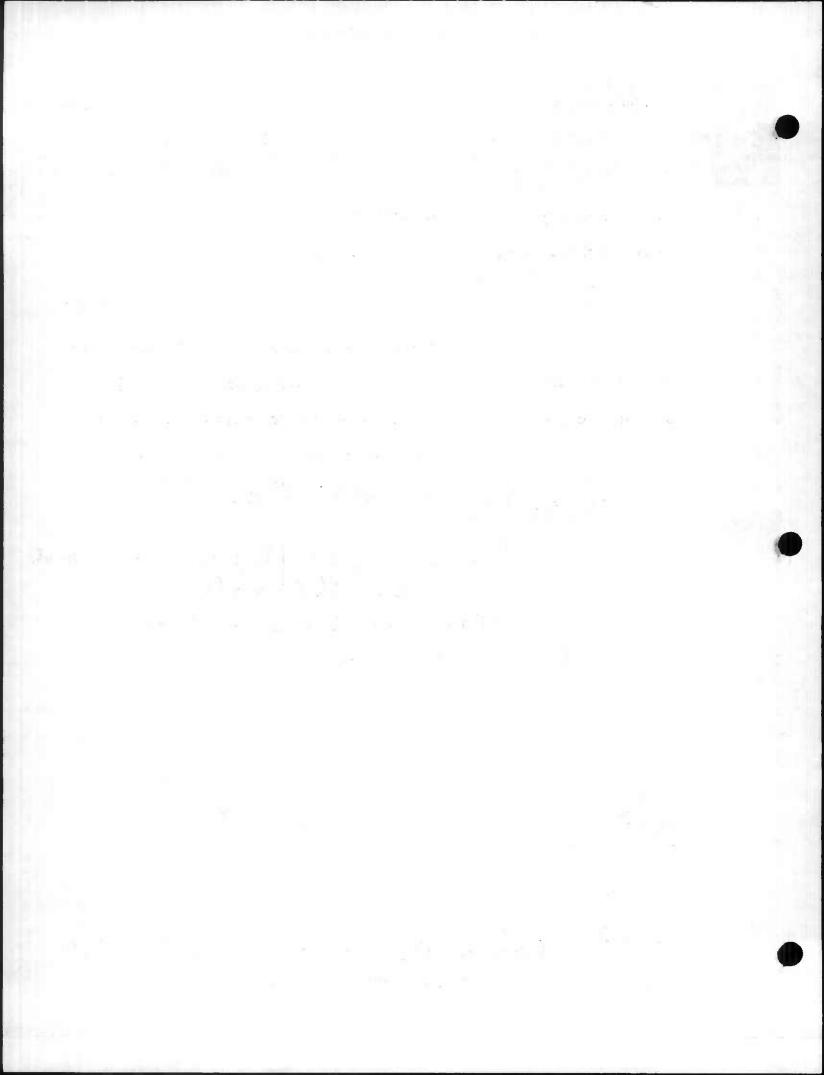
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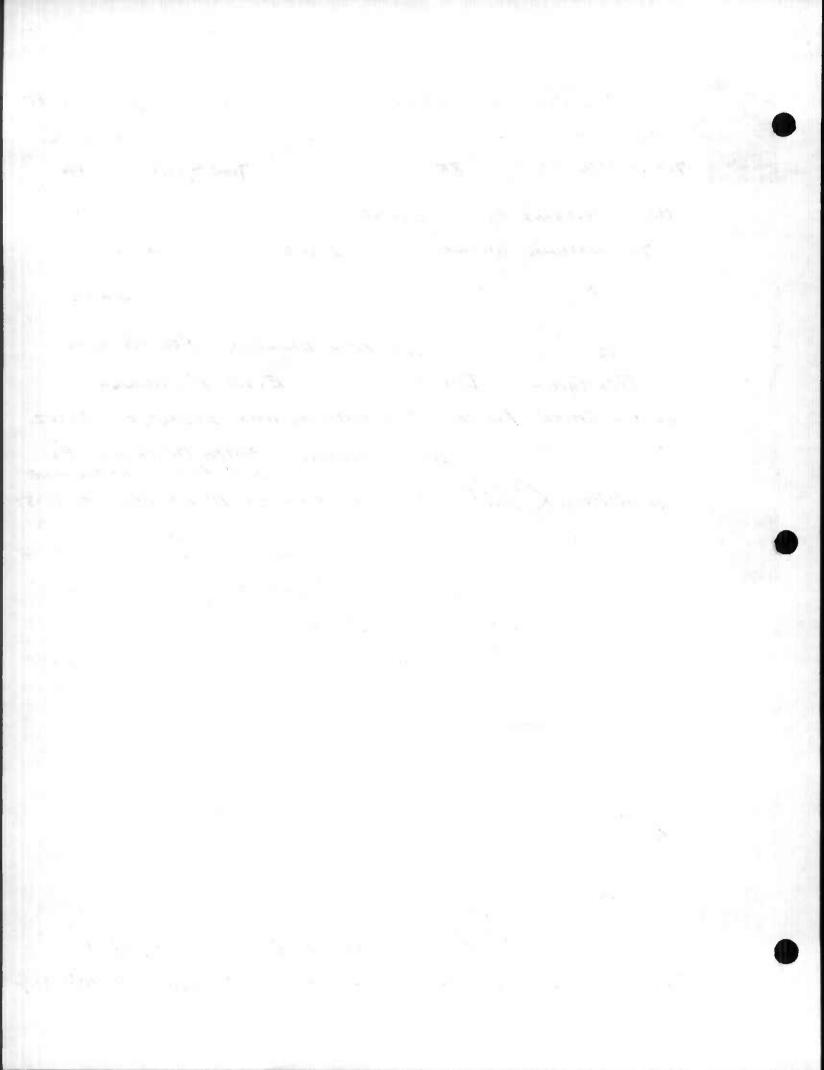
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State of Maryland / Department of Health and Mental Hygiene 9 07224

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** FRANK NMN **JAMES** 18, 1999 February 11:30am /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 206 S. Church Street Sharpsburg Washington H Under 1 Yeer H Under 24 Hrs.
Months Deys Hours Min.
Month Deys Hours Min.
March 15 1 5. Social Security Number 7. Age (In yrs. last birthdey) Birthpiece (State or Foreign Country) **Funeral** Months 1⊠M 2□F Yrs. 220-32-6872 60 1938 Director Tennéssee Usuel Residence of Decedent with the Meryland 10a. State 10c. City, Town or Location 10b. County 10d. inside City Limits rail, or items 23s or 28s-f show Examiner rount be notified at Maryland Washington Sharpsburg 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 206 S. Church Street 21782 pemit. Pages 1 and 2 should be filed within 72 hours efter deeth v Department of Heelth and Meniel Hygiena. Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic avent, the Medical Experient courts once. United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Yes 2 🗷 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Heavy Equipment Operator Excavating 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Samue1 James Bonnie Livesay 2 19a. informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 206 S. Church Street, Sharpsburg, Maryland 21782 Clara L. James / Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriet 2 □ Cremetion 3 □ Removel from Stete 2/23/99 Seals Farm Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Etchison, Maryland 21. Signeture of Funeral Service Licenses AZ. Name and Address of Fecility
Muriel H. Barber Funeral Home rill - Warke P. O. Box 5038, Laytonsville, Maryland 20882 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Betw Onset and Deeth **Physician** immediate Cause (Finel disease or condition resulting in deeth) /Medicai Gunshot wound to Chest moments Examiner Due to (or es a consequence of): Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or es e consequence of): Division of VItal Records, P.O. Box 68760. Due to (or es e consequence of) attending pl signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Severe Chronic Obstructive Pulmonary Disease þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en autopsy performed? Completed After this certificate hes funeral director, page 2: 1 TYes 2 NO 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residenca 6 ☐ Other (Specify) Certification: To 1 X Yes 2 □ No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Self-Inflicted gunshot wound to chest 1 Naturei 1 Yes 2 No 11:30 2 Accident February 18, 1999 To the Hospital or Atter s within 24 hours after des To the Funeral Director completely filled in by th 6 Could not be determined 3X Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide AT HOME 206 S. Church St Sharpsburg, MD edicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner steted. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) W. Dittos 19, 1999 DO1062 February 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Edward W. Ditto, 31. Date filed (Month, Dey, Year) 21740 217 W. Washington St. Hagerstown, Md M.D. III, 32. Registrer's Signeture State FEB 2 2 1999

Registrar

dage fermion 4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** CAROL W. JESSUP 11.05 PM FEB 19 1999 /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Jan. 30, 1 COLUMBIA HOWARD COUNTY GENERAL HOSPITAL HOWARD Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 XF 1920 North Carolina 214-12-7430 Director **Usual Residence of Decedent** 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Columbia 28s-f MD Howard 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21046 USA 23a 10271 Wayover Way Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important if them 27 is marked other any injury or other training. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White PV 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Space Dept. Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins, APL Senior Secretary 17 Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surname) Claire Barnett Hawkins Edward Iverson Stacy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 10271 Wayover Way, Columbia, MD 21046 Doug A. Wheeler (son) 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 2 Burial 2 Cremetion 3 Removel from State St. Mark's Episcopal Cem. 2/24/99 Silver Spring, M.

22. Name and Address of Fecility Francis J. Collins Funeral
Home, Inc. 500 University Blvd. West Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fue eral Service Licenses Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** SEVERAL /Medical Immediate Cause (Final . CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) YEARS Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and Box 68760, the attending physician Physician/Medical the Due to (or as a consequence of) US6 25 Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Ves 2 No 3 Probably 4 Unknown STAPHYLOCCUS BACTEREMIA Records, Completed by 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No certificate Division of Vital Attending Physician: funeral director. 88 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 De Natural 5 Pending investigation al or Attending after death. 1 TYes 2 No 2 Accident the 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1 LI MD D0018317 FEB 20 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNARD F. FARRELL MA

Registrar

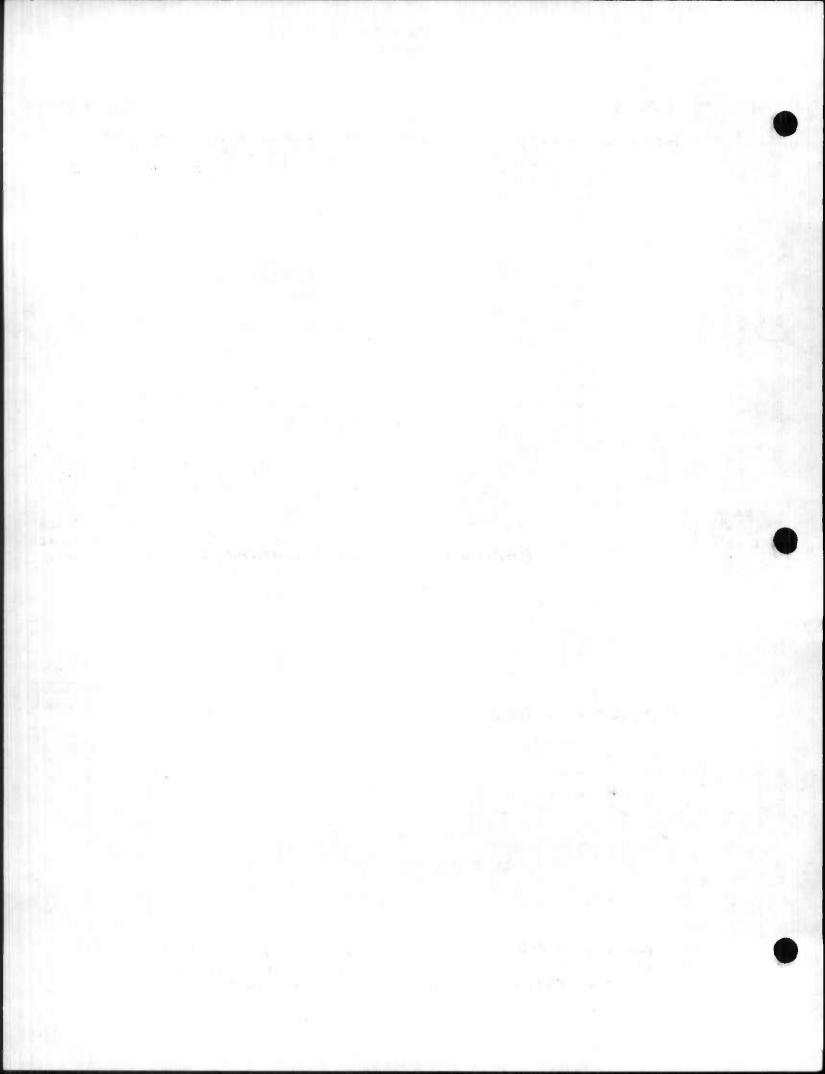
State

COLUMBIA, MOZIO44

11055 LITTLE PATUXENT PKWY,

1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth **Physician** Month -0 JOHNSON, ST 740 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burvie Arundel 7. Age (In yrs. last birthday) If Undar 1 Y orth 8. Dete of Birth (Month, Dey, Year) NOV. 20, 1927 If Undar 1 Yaar Months Days if Undar 24 Hrs. 6 Sav 5. Social Security Number Birthpleca (Stata or Foraign Country) **Funeral** 1M 2□F 243-40-6229 Yrs. Director N. Carolina Usual Residance of Decedent the Maryland 10e State 10b County 10c. City. Town or Location 10d. inside City Limits **ehow** item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel 1 ☐¥es 2 ☐ No Director Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 U.S.A. 8301 Deer Run Court death \ Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) Race - Americen Indian, Black, White, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Black 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiena. Important: If Item 27 is marked other than any injury or other traumatic event. In a Me Elementary/Secondery (0-12) 6th College (1-4or 5+) Milk Co. Fork Life Operator 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Lottie ? John Johnson 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Shirley A. Johnson (Wife) 8301 Deer Run Court, Severn, MD 21144 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 28 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Md Nat'l Memorial Pk 2/23/99 Laurel, MD 21. Signature of Funeral Sarvice Doense 22. Nama and Address of Fecility SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hard feilura. List only one cause on each lina. Approximate Intervel Between Onsat and Deeth **Physician** Poute CArdiac Insufficiency Due to (or as e consequence of): /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner HEART DISEASE Examiner buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last pue Due to (or es e consequence of) certificate be axec Box 68760. inding physician use as the burie Physician/Medical Due to (or as a consequence of): attending P.O. signed by the si Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Records, þ should l Completed 24a. Was en eutopsy periormed? 24b. Were autopsy findings available prior to complation of cause of deeth? page 2 hes 2 No Aftar this cartificate 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 2 1 ☐ Inpetient 2 ER/Outpatient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) nner of Death To the Hospital or Attending Pr within 24 hours aftar deeth. To the Funeral Director: Aftar th completaly filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) end manner steted.

Deputy

ones, mo

32. Registrar's Signetura

ss of person who completed ause of death (Item 23e) (Type, Print)

mo

State Registrar

29a. Certifier

(Check only

31. Date filed (Month,

29b. Signature end title of certifian

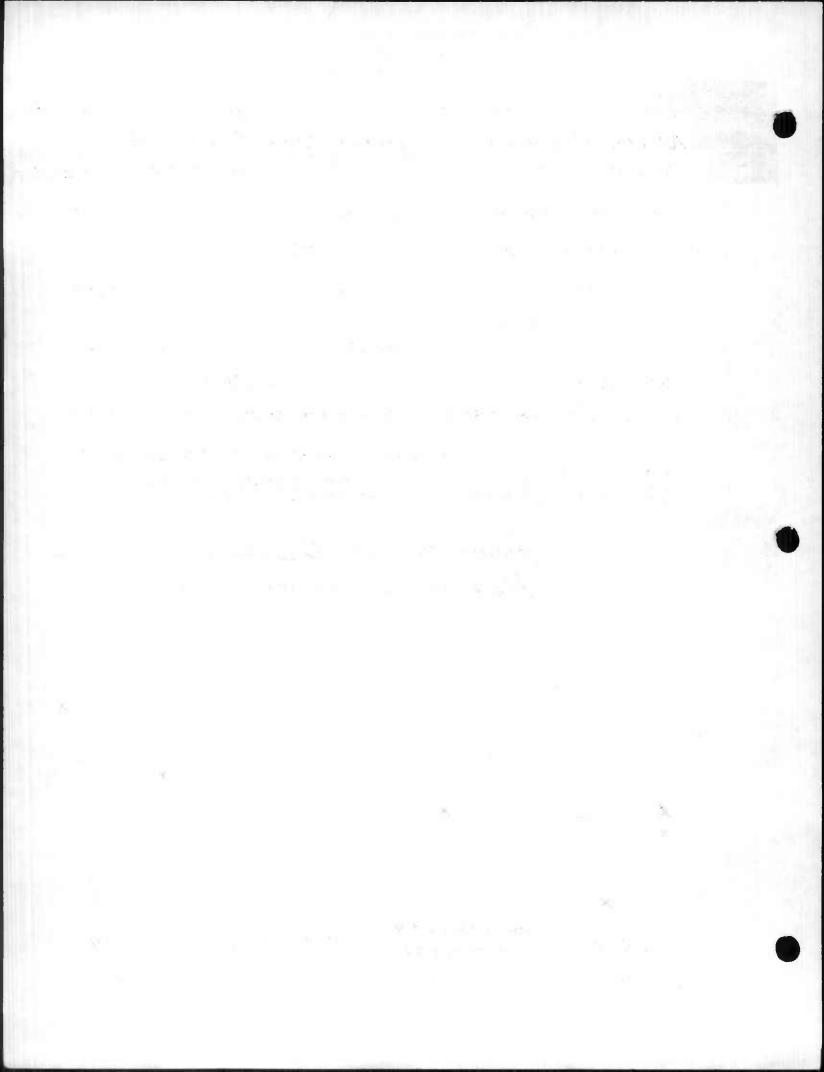
EB 23

DHMH 16 Rev 6/95

29d. Dete signed (Month, Dey, Year)

29c. Licansa number

America Ct 21035



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

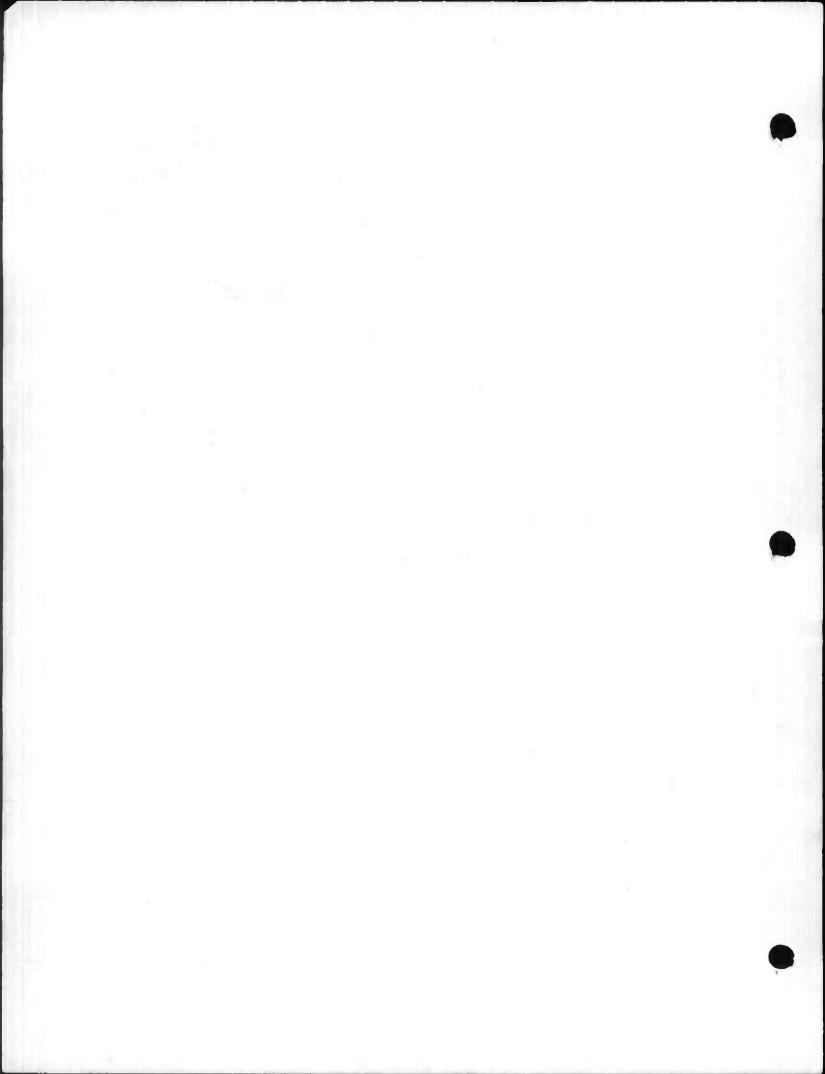
Star Fuller

TO THE HOSPITAL OR ATTENOING PHYSICIAN: The law requires that the death certificate be executed within 6. Hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If them 28 is marked, or lifem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Las	et)				2. DATE OF DEATH	c	3. TIME OF DEATH
	LINDA	JONES				MONTH DA		F 40 M
- 1	4. SOCIAL SECURITY NUMBER		in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	FEBRUARY 7. DATE OF BIRTH		5:42 pm M
	243-76-9250	1 M 2 💢 F	52 YRS.	MONTHS DAYS	HOURS MIN.	March 16,	1946 Count	NC NC
DIRECTOR	99. FACILITY NAME (# not Institution, gh Washington Adve	ntist Hospital			R LOCATION OF DE	ATH	9c. COUNTY OF D	gomery
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COU		T too CITY	TOWN OR LOCAT	ION			10d, INSIDE CITY
	DC DC	NA NA						LIMITS?
9		IVA	l W	ashingt				YES 2 NO
FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN OF	WHAI COUNTRY?
9 1	6118 Sligo Mill				2001			d States
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED			IC ORIGIN? (Specify Yes n, Puerlo Rican, atc.)	or No- 14. RAC Blac	E - American Indian, k, White, etc.
ВУ	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES X		2 NO Specify		Spec	Black
						100		DIGCI1
COMPLETED	15. DECEDENT'S E (Specify only highest gr		16a. DECEDENT'S U	ork done during mo		16b. KIND OF BUS	SINESS/INDUSTRY	
91	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use					
A		4	0	perator			phone	
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden	Sumame)	4
BE	John M. Peak				Doroth	ny Love		7.2
TO B	19a. INFORMANT'S NAME (Type/Print)		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Route Number, City or Town		
F	John D. Jones -	Husband	6118	Sligo M	111 Road	N. E., W	ash., DC	20011
	20e. METNOD OF DISPOSITION 1 Buriel 2 Cremation 3 5 R		. PLACE OF DISPOS other place)	TION (Name of cer	netery, crematory or	20c. LO	CATION — City or T	own, State
	4 Donation 5 Other (Specify)		Dakwood N				gh Point	, NC
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			D ADDRESS OF FA			
	> X. Yr S	Lorlan	Page Grand			Co. Mortic		
	23. PART I. Enter the diseases,	or complications that caused	d the death. Do n					DC 20011 Approximate
	shock, or heart fallu	re. Liat only one cause on e			, , , , , , , , , , , , , , , , , , , ,			Intarval Batween Onset and Deeth
- 1	IMMEDIATE CAUSE (Finel disesse or condition	b. DUE TO (OR AS A		1	17	10000		. (/
	resulting in death)	S. DUE TO OR AS A	CONSEQUENCE OF	CANC	100 71	VEHICTIO	H	9005
		Pulm		(E) E.	10			lu bar
CERTIFICATION	Sequentially list conditions,	b. DUE TO (OR AS A	CONSEQUENCE OF):	(7			9 11125
¥.	if eny, leading to immediate cause. Enter UNDERLYING							
윤	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF):				1
E	resulting in death) LAST	4						
7	PART II. Other significant condi	tions contributing to death b	out not resulting i	n the underlyin	g cause given in	Part I. 24a. WAS AN PERFOI		b. WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO
용						1 _ YES 2	TINO	OMPLETION OF CAUSE OF DEATH?
MEDIC						_		1 - YES 2 - NO
ä								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?				LACE OF GEATN (Ch	eck only one)		
Sign	1 VES 2 NO	HOSPITAL: 1 inpatient 2 in ER/Out	petient 3 🗆 DOA	OTHER: 4 - Nursing Hor	ne 5 🗆 Residence	8 Other (Specify)		
Ŧ	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		JURY AT	28d. OEŞCRIBE NOW	INJURY OCCUREO	
	1 Natural 5 Pending		100		YES 2 NO			
) BY	2 Accident Investigation 3 Suicide 6 Could not	28e. PLACE OF INJURY	Y At home, farm, s	treet, factory, offic	:0	28f. LOCATION (Street City or Town, State	and Number or Rura	l Route Number,
TED	4 Nomicide determine		City)			City of lown, State,	,	
COMPLET	290. CERTIFIER DE CERTIFYING P	HYSICIAN: To the best of my know	viedge, death necum	ed at the time dat	and place, and due	to the causelet and ma	nner as stated	
MP	(Critick only	MINER: On the basis of examination						o(a) and manner as stated.
8	4			7				
BE	29b. SIGNATURE AND TITLE OF CRUT	IFIER /			29c. LICENSE NU	A D D	29d. DATE STENE	ED (Month, Day, Year)
9	30, NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DE	EATH RITEM OF CO.	Orient)	17700) /d	1-6/6	4177
	30. HAD ANDRESS OF PERSON	T/ _ \	1).	1 AADE		, D.	1- 1-	. A
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	(W) N O	1 17	- / 1) (024 10	JC 1	
		999 Berev	4	lan "	,		6	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month Yaar **Physician** February 17 1999 catlon of Death 4c. County of Deeth 8:50 PM William R. Jones /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Heartland Healthcare Hyattsville Prince Georges If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 9. Birthpiece (Stete or Foraign Uly 16, 1920 Virginia 5. Sociel Security Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) **Funeral** Months Hours 11XM 2□ F 78 **Director** 223-30-2227 Usuei Residance of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Insida City Limits the Maryla Director 1 ☐ Yes 2 ☒ No MD Prince Georges Hyattsville 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 6509 Flander Drive 20783 USA Funeral 12. Was Decedent Evar In U,S. Armed Forces? 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indian, Bieck, White, atc. 1 Never Married 2 Married 1 ☐ Yas 2 ☒ No If Yes, Give b Baltimore, Maryland 21215-0020 1 ☐ Yes 2 A No Specify: P Specify: White 3 Widowed 4 Divorced Yeer or Detes Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: if item 27 is marked other than any injury or other traumatic event the Ma Elementery/Secondery (0-12) College (1-4or 5+) 12 Milkman Dairy Delivery 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Marvin L. Jones Ruth M. Keys 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 6509 Flander Drive, Hyattsville, MD Arlene L. Jones (wife) 20e. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stete 1 ☑ Burlai 2 ☐ Crametion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 2/22/99 Brentwood, MD 22. Nama and Addrass of Facility Francis J. Collins Funeral 21. Signature Funeral Service Licen 500 University Blvd. West Home, Inc. Silver Spring, MD 20901 ions thet caused the deeth. Do not enter tha mode of dying, such as cardiec or respiretory errest, eusa on each line. Approximate Intervai Between Onset and Death **Physician** /Medical Immediate Cause (Finel Intra cebral Hemorrhage 1 month diseasa or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner 'ARDIOVASCULAR 1) 'SEASE ARTORIOSCLEROTIC (YRARS ettending physician and for use as the burial-transit be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 98 signed by the elid be detached in Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed page 2 1 ☐ Yes 2 1 No certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

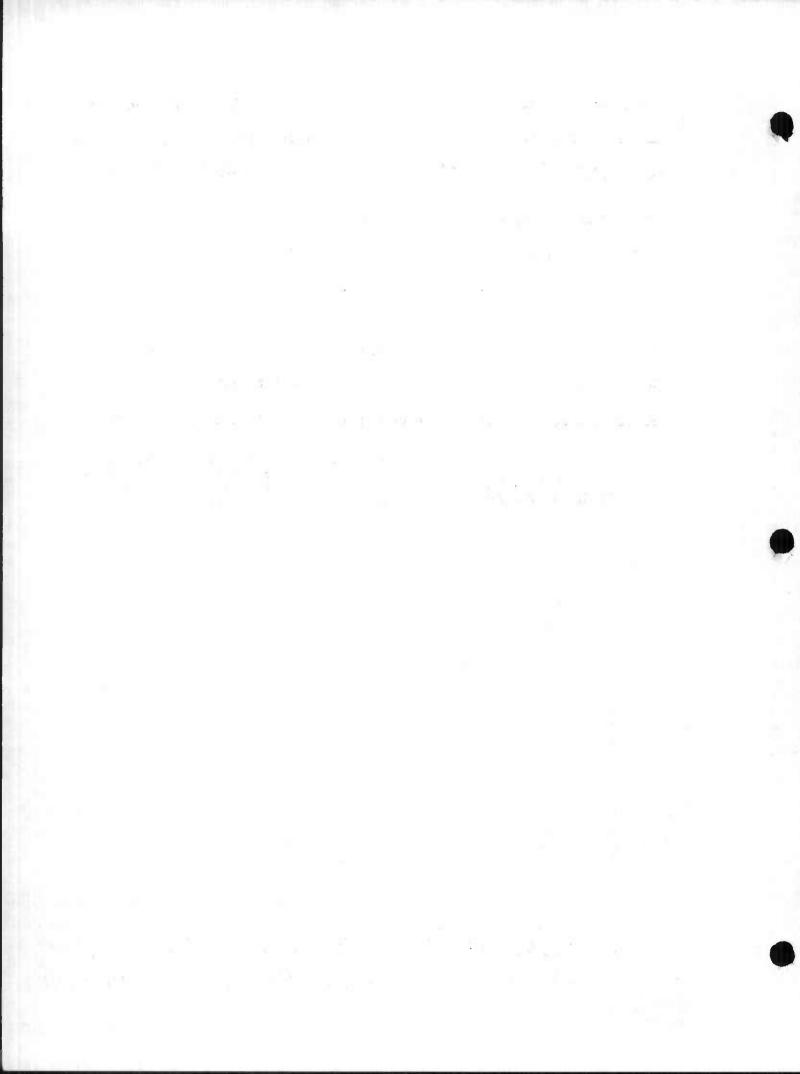
To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending Invastigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be detarmined 28a. Piace of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 4 Homicide edicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end mennar stated. 29b. Signeture end title of certifier 29d. Deta signed (Month, Dey, Year) 30 Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Ducensbury Rd HyaTTSVILLE MID 20781 AUL A. DEVORE MID

State Registrar

31. Dete filed (Month, Day, Year) FEB 2 2 1999

42031 32. Registrer's Signature

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death 3. Time of Death TONES Month 11:22 Physician WALTER February 20 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVESITY OF MARYLAND MEDICAL SYSTEM BALTIMORE Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year)

Apri 02,1939 5. Social Security Number If Under 1 Year Birthplaca (Stata or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** Days 220-34-7638 18 M 2□ F 59 Yrs. Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Wedlosi Examiner must be notified at 1 Yas 2 □ No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 604-B Hubert Street Funeral 21613 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, Whita, atc. filed within 72 hours effer. Hygiene. Wher then "natural; or ite 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore. Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled wit.
Department of Heelth and Mental Physiera.
Important: if item 27 is marked other that eny injury or other treumatic event, that other Line Feeder Seafood Factory 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 8 Jones, Milton Sr. Ethe1 Wongus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Twilliamae Kane (daughter) 604 B, Hubert Street, Cambridge, Maryland 21613 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Deta 1.2 Burial 2 Cremation 3 Removal from State Salem Cemetery 2/27/99 4 ☐ Donation 5 ☐ Other (Specify) Salem, Maryland 21. Signature of Funeral Service Lies 22. Nama and Addrass of Fecility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onsel and Death Physician /Medical Immediate Cause (Final 10 days Klebsiella disease or condition resulting in death) SEPSIS Examiner Due to (or as a consequence of): Examiner ettending physicien and for use es the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by the 1 Yea 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? peeu Completed 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: T s after death. I Director: After this certificat 25. Was case referred to medicat examiner? 8 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 No To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 Yas 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) To the Hospital or A within 24 hours effer To the Funeral Directomplately filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier MD P11744 February 20, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University of Maryland Medical System Clevenger 31. Data filed (Month, Day, Year) 32. Registrar'a Signature State FEB 23 Registrar

desired that the personal 125 N. S. S. S. S. S. S. S. P. Lander Street degree a registrate

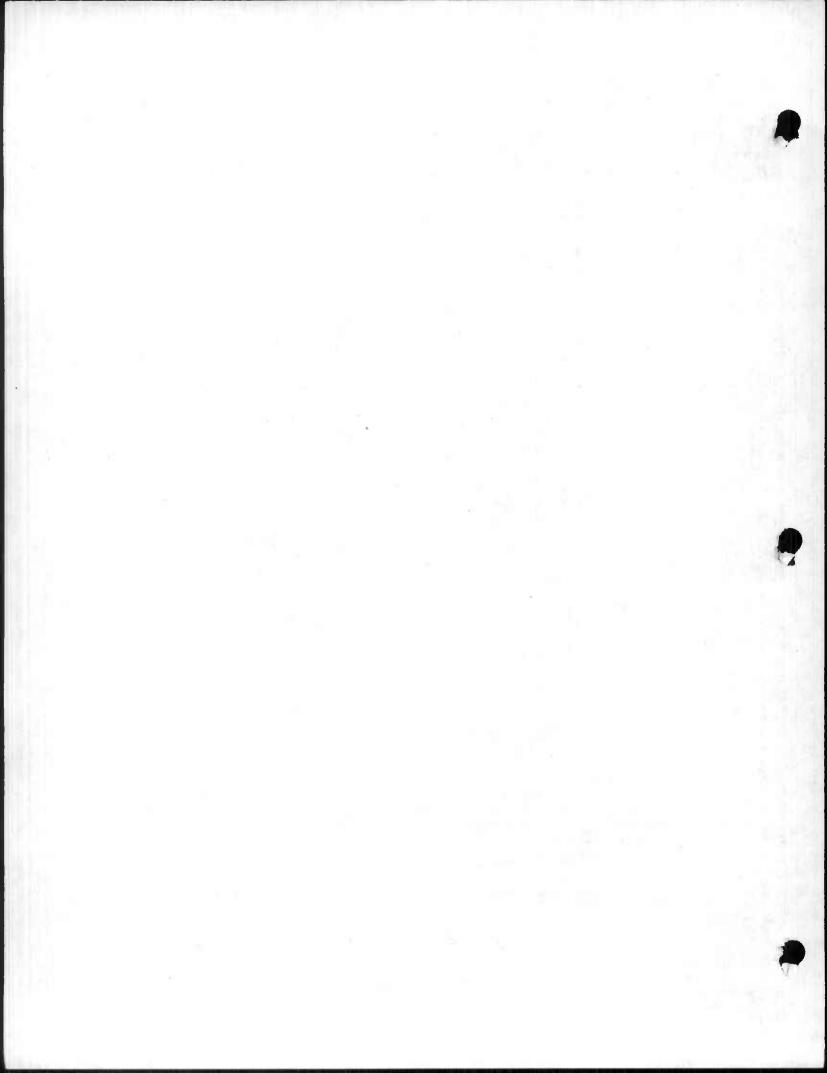
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, La		iai yiai	-			Death	iviental ny	Reg. No.	99	07231
Physic		Frank Marshall Jol							2. Dete of De Month	Dey	Yeer	3. Time of Deeth
/Med Exam		4e. Fecility Neme (If not institution, give)				4b. City, Town, or	Februa Location of Dear		1999 unty of Deeth	0205 am
Laum		The Kent & Queen	Anne's Ho	spita	al Inc.		-	Chestert		Kent		
Funera Directo		5. Sociel Security Number 6. S 220-26-1447		ge (In yrs.	lest birthday) 2 Yrs.	If Und Month	ler 1 Year s Deys	If Under 24 Hr Hours Mir	8. Dete of Bi (Month, D March	rth ey, Yeer) 27, 19	9. Birth Cou	piece (Stete or Foreig intry) ryland
anyland show		Usuel Residence of Decedent 10a. Stete 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
the Maryia 7 28a-f ehov	ctor	Maryland Kent		Mil	lingto	n						1 Yes 2 No
A G	al Dire	10e. Street end Number 1602 Dudley's Corn	ner Road			10f. 2	2165	1		10g. Citizen	of Whet Cou	untry?
ter dea items	by Funeral Director	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces 1 Yes 20 If Yes, Give Yeer or Detes:	?			edent of I becify Cub		Specify Yes or Norto Rican, etc.)	D- 14.	Reca - Amer Bleck, White ecity: Wh	, etc.
21215- d within 72 piene. r than "nat	Completed	15. Decedent's Ec (Specify only highest green Elementery/Secondary (0-12)	ducation ode completed) College (1-4or	5+)	life. L	kind of v OO NOT	vork done use retire	during most of we	orking		of Business/I	ndustry
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ylan ould be Mental arkad o	ToE	Harry L. Johnson						Flora V	anSant			
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ire, Maryland stand 2 stand 2 should be filed f Health and Mantal Hygitam 27 is marked other traumetic event,		Dorothy Mae Johnson	on/Wife		1602 1	Oud1	eys (Corner R	oad, Mil			21651
		20e. Method of Disposition 1 ☒ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specification of the content			Place of Disposemetery, crem mpton (2/26/99		on - City or Toton, I	
Baltimo permit. Pege Depertment of important: if any injury or once.		21. Signeture of Funerel Service	0611	Pair) Fe.	Name Llow	ond Addre	ss of Fecility elfenbei	n & Newn	am Fur		Home, P.A.
	Г	23e. Pert1. Enter the disease, or compshock, or heart feilure. List only	pilcetic of thet cause one cause on each i	d the deet ine.	h. Do not ente) Sp or the m	eer I	Road, Chang, such es cardia	estertow ac or respiretory e	n, MD	21620	Approximete intervei Between Onset end Deeth
Physician /Medical Examiner	Je.	immediete Ceuse (Finei diseese or condition resulting in death)	· Aco		or es e consequ			170=V	mercy			3 Hours
68760, trificate be executed g physician end as the bunal-transit	al Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events	b. ———	Due to (c	er es e consequ	uence of	·):					
cords, P.O. Box 68/60, requires that the death certificate be execut seen signed by the attending physician end hould be detached for use as the burial-tran	an/Medical	thet initiated events resulting in deeth) Lest	d	Due to (or es e consequence of):								
deat death	Physician/N	Pert ii. Other significant conditions co	ontributing to death b	ut not res	ulting in the un	derlying	cause giv	en in Pert I.	23b. Did	tobacco use	contribute	to the cause of death
igned by the a	by Phy								10	Yes 200	lo 3□Pro	obably 4 Unknow
2 × × × ×	Completed t								24e. Wes	en eutopsy ermed?	C	Vere eutopsy findings veilable prior to completion of cause if deeth?
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LIVISION To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury - At ho	ome, ferm, stre	M et, facto	1 🗆	Yes 2□No			ım <i>ber</i> or Rur	al Route Number,
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within 2 To the	M	29b. Signeture end title of cartifier				25	ç. Licens			29d. Date sig	gned (Month,	Dey, Year)
	8	Jue c sy	- mus				1)-	13824		2-2	2-59	
		30. Neme and address of person whole John C. Seymour, 1	22 Speer 1	Road,	Suite		Ches	tertown,	MD 216	520		
Sta Regist	_	31. Dete filed (Month, Dey, Yeer) FEB 2 4	1999 32. Regist	ar's Signe	ture &		door	61				

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth **Physician** Month F E B 2 Dey 1 9 9 9 RUTH G. JOHNSON 3:15 AM /Medical 4e. Fecliity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 11988 NATIONAL PIKE GRANTSVILLE GARRETT | Hunder 1 Year | Hunder 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | O C T 30, Year | 16 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign Country) MARYLAND **Funerai** 10 M 20 F 215-12-2208 Yrs Director 82 Usuei Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23s or 28s-f show suical Examiner must be notified at Director 1 Yes 2 No MARYLAND GARRETT GRANTSVILLE 10e. Street end Number 10f, Zip Code 10a. Citizen of Whet Country? 11988 NATIONAL PIKE 21536 USA deeth Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Pages 1 and 2 should be filed within 72 hours eftar can of Heelih and Mental Hygiena.
Int: If Itam 27 Is marked other than "natural", or ites
Inty or other traumatic event, the Medical Experies
Inty or other traumatic event, the Medical Experies Bleck, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Completed by Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be GEORGE T. BECKMAN LILLIE MAY WALTERS 19e. tnforment's Name/Reletionship (Type, Pnnt) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CHARLES JOHNSON 435 HAPPY HILLS LANE, FROSTBURG, MD 21532 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) FEB 20c. Location - City or Town, State 23, 19999 1 Burlel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or once. REST LAWN MEMORIAL GARDENS LA VALE, MD 21502 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502 23e. Pert 1. Enter the disease, or complications that caused the cleath. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Congestive Examiner Physician/Medical Examiner shys function Dastelie feens The law requires that the death certificate be axecuted the burial-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest pug Records, P.O. Box 68760, 42ans Ventnenler Due to (or es e consequence of) for use es Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? is cermicate has been signed by director, pege 2 should be detect Chronic atrial fibrillation. Plumal 1 Yes 2 No 3 Probably 4 Unknown Be Completed by Poss mass in CO PD. 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy After this certificate has lung 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes cese referred to medical exeminer? 28. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA // s after dec. 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide ò To the Hospital o Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) om dlin Ma FEB 22,1999 30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) me S.L. SANDHIR, 48 TARN TERRACE, FROSTBURG, MD 21532 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Month **Letty Dillon Johnson** 12:30 PM FEBRUARY 22 1999 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Allegany Sacred Heart Hospital Cumberland If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Dey, Year) Deys 1 ☐ M 2 X F Yrs. 220-10-4372 13-Jul-14 Maryland Usual Rasidence of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ¥Yas 2 □ No Maryland Allegany Cumberland 10g. Citizan of What Country? 10e. Street and Number 10f, Zip Coda 15 Cherokee Drive 21502-12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) College (1-4or 5+) teacher education 17. Fethar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) J. Fred Dillon **Eva Dando** 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Maryland 21539-Sandra Grandstaff Niece Longconing 39 East Railroad Street 20b. Place of Disposition (Nama of cematery, crametory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 27-Feb-99 Frostburg, Maryland Frostburg Memorial Park 21. Signatura of Funaral Sarvice License 22. Nama and Addrass of Facility bleu Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Betwean Onsat and Death Immediata Causa (Finel disaasa or condition rasulting in daath) PNEMMONIA Sequentially list conditions, if any, leeding to immediate cause. Entar Undarlying Causa (Diseasa or injury that initiated events rasulting in daeth) Lasf Dua to (or as a consaguance of): Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 Yas 2 PNo 1 Yas 2 No 25. Was casa ratarrad to medical examiner? 1 Yas 2 No 26. Placa of Daeth (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

12

Director

Funeral

b

Completed

Be

Funeral

Director

ir than "netural", or Itams 23a or the Medical Examiner must be r

the Marylend

r death

Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mentel Hygiene.

Item 27

Depertment of Important: If the any Injury or o

other

Baltimore, Maryland 21215-0020

Examiner physician and the buriel-transit Physician/Medical 98 950 p Completed Be 2 Certification:

signed by the e is certificate hes director, page 2 this funeral efter death. To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Division of Vital Records, P.O. Box 68760,

the death certificate be executed Hospital or Attending

Registrar

State

edicai

who complated causa of death (Itam 23a) (Type, Print) DRIVE

5 Panding

invastigation

6 Could not be

Hospital:

1 Impatiant

28a. Dete of Injury (Month, Dey Yeer)

1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) and mannar es steted.

2 Medical Examinar: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and plece, end due to the causa(s) and mannar stated. 29b. Signatura and title of certifier

2 ER/Outpatient 3 DOA

28b. Tima of

28e. Plece of Injury - At home, farm, streat, factory, office building, atc. (Specify)

29c. Licanse number

28c. Injury at Work?

29d. Data signad (Month, Day, Year)

Location (Street and Number or Rural Routa Number, City or Town, Stete)

Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify)

28d. Dascribe how Injury occurred

FEBRUARY 241999

1 ☐ Yas 2 ☐ No

VIRGINIA6 . MAGROUS, MY

31. Deta filad (Month, Day, FEB %

27. Manner of Death

1. Natural

2 Accident

3 Suicida

29a. Cartifian

4 Homicida

32 Aggistrar's Signatura

Letty Dillon Johnson Allegony Cumbedond Sacred Heart Hospital 220-10-4372 13-Jul-14 Maryland 84 Cumberland Allegany Maryland 15 Cherokee Drive U.S.A. White nortropuba teacher 12 Eva Dando J. Fred Dillon 39 East Railroad Street Lonaconina Maryland 21539-Sandra Grandstaff Frostburg Memorial Fork 27-Feb-99 Flostburg, Maryland

Durst Funeral Home. 57 Frost Ave., Frostburg, MD 21532

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day -Month Benjamin Franklin Kunkleman 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not Institution, give street and number) Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) M 2 F Yrs. 213-18-9841 March 21, 1923 Maryland Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Hagerstown Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1325 Hamilton Boulevard 21742 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1X Yes 2 No WW2 1 ☐ Yes 2 ☒ No Specify: specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Deles: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) President Brandt Cabinet Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John Kunkleman Mae Ott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1325 Hamilton Boulevard Hagerstown, Md. 21742 lace of Disposition (Neme of Dete 20c. Location - City or Town, State June M. Kunkleman Wife 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stele Rest Haven Cemetery 2/26/99 Hagerstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one ceuse on each line. Interval Between Onset and Death Innoliste Immediate Causa (Final disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Onatural 5 Pending

Examiner

Kunkleman,

Division

Attending

Examiner Physician/Medical þ Be Completed edical Certification: To ve Hospital or Attendin, n 24 hours after death. ve Funeral Director: Aft pletely filled in by the fur

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28a-f show Examiner must be notified at

"natural", or Hame

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Media page.

Physician

/Medical

72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

25. Was case referred to medical 1 Yes 27. Manney of Death

2 Accident

3 Suicide

28a. Dete of Injury (Month, Dey Year)

1 Tyes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Homicide 29a. Certifier 1 Lertifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

29c. License number Ap26523 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medica LADRES 11110

investigation

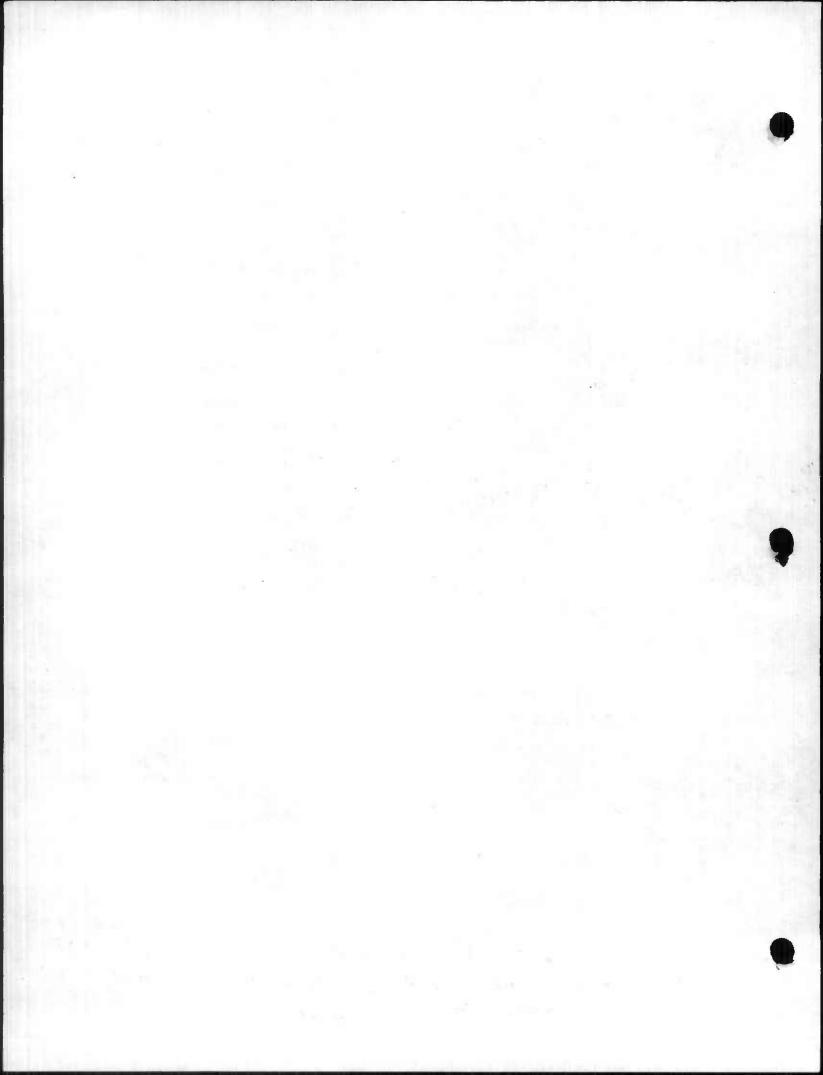
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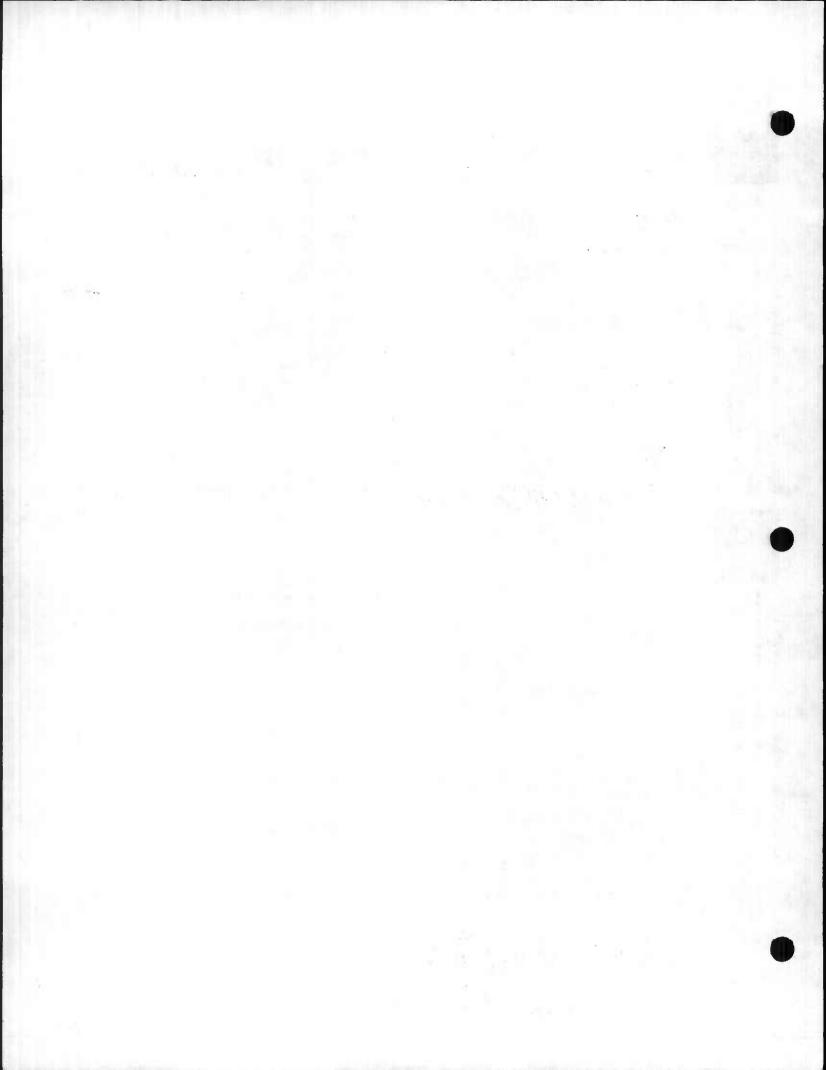
State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 3 1999

To the Hosp within 24 ho To the Fune completely fi



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	Physicia /Medic	_	1. Decedent's Nam Douglas	Brian	KELLER							2. Date of D Mgnth 78674	eath Day ary 21,	Yaar 1810	
0.1	Examin	er	4a Facility Name (/ Washingt	on Cou	nty Hos	spita	1		Milada		Hagers	town		Washington	
L	Funeral Director		5. Social Security N 215-90-20 Usual Residence of	166	6. Sex		36	last birthday) Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Data of Bi (Month, D Nov	rth ay, Year) 30,1962	9. Birthplace (State of Country) Maryland	or Foreign
	72 hours after death with the Maryland natural, or Items 23s or 28s-f show deat Examinar must be notified at	ector	10a. State Maryland	10b. County Wa	shingto	on	10c. C	ty, Town or Lo Smi	thsbu						ity Limits 2X) No
	urs after death with the Merylar at', or items 23s or 28s-f show Examiner must be notified at	Funeral Director	Berry C		12. Wa	s Deceder	nt Ever in L	10f. Zip Code 2 2 rer in U,S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, If Yes, specify Cuban, If Yes, spec			2178		10g. Citizen of US		
020	ours after d	þ	1⊠ Never Marri 3 ☐ Widowed		ried 1 [ned Force Yes 2 es, Give ar or Dates	s? No				in, Mexican, Puerto Specify:	Rican, etc.) Black, Whi		ck, White, etc.	
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Maryland 2	should be filed nd Mental Hygid marked other umatic event, to	To Be C	17. Father's Name (First, Middle, Last) Larry Eugene Keller 18. Mother's Name (First, Middle, Maiden Surmame) Donna Lynn Bush							ne)					
	1 and 2 sh Health and Pm 27 is m ther traum		19a. Informant's Ne Donna Ke 20a. Method of Disp	11er -		1151	201)	109	17 Oa	k Fo			rstown,	Md. 21740 City or Town, Stata	
Baltimore,	Pages nent of ant: If it		1 Burial 2	☐ Cremation 5 ☐ Other (S	pecify)	I from Stat	Θ	Place of Dispondermetery, cres	m Mei	m. P	ark 2-	-24-99		town,Maryl	and
Ba	permit. Departri Importa any inju		23a. Part1. Enter the shock, or hea	Coll	M	that caus	MCa ed the dea	4	15 E.	Wil.	son Blvd.	, Hage	rstown,	Md. 21740 Approximat	8
	Physician /Medical Examiner		Immediate Cause (disease or condition resulting in death)	Final	a	Hypo	oxia							Onset and	Death
-	executed an and unal-transit	Examiner	Sequentially list co	nditions	b	Statu	is E	or as a consec	oteo	us		8	3 1	year	5
Box 68760,	n certificata be inding physicia use as tha bur	Physician/Medical Ex	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events rasulting in death) I	injury	c	Con		or as a conseq	bence of):			11able	Seizur	CS	
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	iw requires that s been signed b 2 should be deta	Completed by										24a. Wa	s an autopsy omed?	24b. Were autopsy available prior completion of o	lo
ital Re	ysician: Tha law is certificate has b director, page 2 s	Be Com	History 25. Was casa reference examiner?	of H		gton	is I)is easo	2		26. Place of Deat		Yes 2 No	1 Yas 2	No
Division of Vital Records,	2 000	2	1 Yes 2 X 27. Manner of Death 1 X Natural 2 Accident	5 Pendin	ation	Date of In (Month, D		28b. Time of Injury		Bc. Injun	4 LI Nursing Ho		how injury occur		
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ı	Star Registra		31. Date filed (Mont	Savai th, Day, Year) EB 2 4		32. Regis	(Contrar's Sign	Mediatura &.	CAL	Ca	mgus	Rd	Hag.	md.	



			State	of Man	yland / Depa <i>Cel</i>	artment of rtificate o			lental Hy	/giene Reg. No.	20	07226
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Funeral Director		5. Social Security Number 215–12–2589	Sex 1⊠M 2□F	7. Age (I	n yrs. last birthday) 77 Yrs.	If Under 1 Ye Months Day		If Under 24 Hrs. Hours Min.	8. Data of Bi (Month, D Mar. 20), 1921	9. Bi	rthplaca (Stata or Foraign country) aryland
after death with the Maryland or herrs 23s or 28s-f show ridges man be notified at Engage.			ngton C		Oc. City, Town or Lo	town	town			10		10d. Inside City Limits 1 ☐ Yas 2 💸 No
3a or 2	2	10e. Street and Number 18922 Dover Dri	ve			10f. Zip Code		742			10g. Citizen of What Country? USA	
S - 1	by runer	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Dec	orces?	14 142	. Was Decedent of Hispanic Origin? (Specify Yas If Yes, specify Cuban, Mexican, Puerlo Rican, at 1 ☐ Yas 2 【※No Specify:				(as or No- , etc.) 14. Race - American In- Black, White, etc. Specify: White		ite, atc.
within then.	ombiered	15. Decedent's (Specify only highest) Elementary/Secondary (0-12) 12	rada completed,	lifa. DO NOT usa retired)					search Co.			
Mental Hyginarked other	0	17. Father's Neme (First, Middla, La Russell Howard						18. Mother's Neme Anna Ru		, Maiden Su	meme)	
alth and 1 27 is ma		19a. intormant's Name/Relationship Doris Robinson		fe.	19b. Mailir 1892	ng Address (Stree 2 Dover	D:	rive, Hac	Poute Numi Jerstow	per, City or To	ylanc	Zip Code) 21742
Pages 1 and of He int: If item		20a. Mathod of Disposition 1 Rurial 2 Cramation 3 4 Donetion 5 Other (Spe			20b. Place of Dispo cemetery, crer Cedar La	natory or other r	Na ce	al Park I	Data Teb.22			r Town, State n, Maryland
permit. Pa Departmen Important: any Injury		21. Signature of Funaral Sarvice Lic	ensee	14,	D	Nama and Add ouglas	A.	Fiery Fu	neral	Home jerstow	vn,Mai	ryland 21742
Physician		23a. Part 1. Enter the disease, or 60 shock, or haart failure. List on	mplications that ly one dause on	1	e deeth. Do not ent	er the mode of o	ying	g, such es cardiac d	or respiratory	arrast,		Approximata Interval Between Onset end Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting In death) a. Acute ischemic Brainstem Stroke 4 a Avitanias (eratic Care brovoscular disease 10)									4 days		
seath certificate be axecuted strenging physician and dror use as the burist-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disassa or Injury that initiated events rasulting in death) Last	b. Hv.7C		e rotto		01	voscela	Ir de	rease	2	10 years
the character ache		Part II. Other significant conditions Drabetes	contributing to d	Los Los	ot resulting in the u	Indertying causa	3	O Years		Yes 2		ts to the cause of death
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Physician: The this certificate ral director, page Co.		25. Was casa ratarred to medical axaminar? 1 ☐ Yas	Hospitel:	Inpatient	2 ☐ ER/Outpatien	t 3 DOA	Otha	26. Place of Deatl			Other (Sn	acity)
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Hospi 24 hou Funer staly fill		29a. Certifier (Check only one) 1 Certifying I	eminer: On tha b	asis of axi	y knowledge, death amination end/or inv	occurred et tha astigation, in m	tim y op	a, deta and placa, pinion, deeth occurr	and dua to the ed et the time	ceuse(s) an , dete end ple	d menner a ece, end di	as stated. ue to the cause(s)
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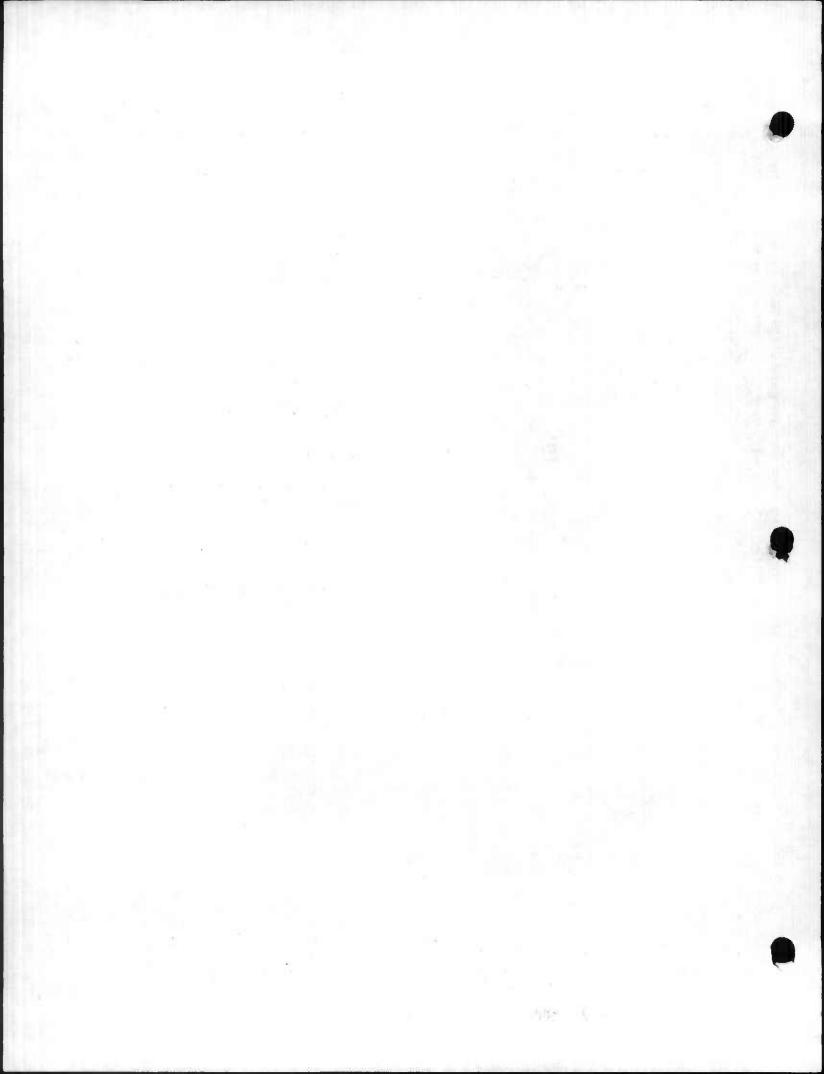
29a. Certifier (Check only one) TE Certifying Physician: To the best of my knowledge, death occurred et the time, deta and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated.

30. Name and address of person who hour BV U
31. Data tiled (Month, Day, Year) State

32. Regfstrar's Signatura FEB 2 2 1999

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day -Month ebruary PATTY J. KIEF 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1□M 2\ F Yrs 69 234-44-6299 1929 NOV 17, WEST VIRGINIA Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BERKELEY MARTINSBURG 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 234 BERNICE AVENUE 25401 USA Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MARTINSBURG Elementery/Secondery (0-12) College (1-4or 5+) COOK DETENTION CENTER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENJAMIN SPITZER EMMA ARMENTROUT 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) KAREN JO THOMPSON/DAUGHTER 225 BERNICE AVENUE, MARTINSBURG, WV 25401 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete RFD 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) TUSCARORA CEMETERY 2-21-99 MARTINSBURG, WV 22. Name and Address of Fecility 21. Signeture of Funerel Service Licenses BROWN FUNERAL HOME, PO BOX 821, hoxles /1 SHOWN 327 W. KING ST., MARTINSBURG, WV 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death artis respiratory arre Immediate Ceuse (Final diseese or condition resulting in deeth) Due to (or as a consequence of): Sepsis Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown achine 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to many artery by flass completion of cause 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Neturel 2 Accident 5 Pending Injury 1 Yes 2 No Investigetion 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Physician/Medical Examiner Box 68760, signed by the al P.O. py Vital Records, Be Completed Attending Physician: Medical Certification: To After this Division within 24 hours after death. To the Funeral Director: A

ò Hospital

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Physician

/Medical

Examiner

Funeral

Director

ral, or hams 23a or 28a-f show. Examiner must be notified at

"natural", or

7 is marked other than "natur traumatic event, the Medical

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "range injury or other traumatic event, to Modes.

Physician

/Medical

Examiner

72 hours after

Baitimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

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1 Yes 2 No Menner of Death

25. Wes case referred to medical exeminer?

6 Could not be determined

281. Location (Street and Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

(Check only 29b. Signeture and title of certifier

29e. Certifier

4 Homicide

29c. License number 20233 29d. Dete signed (Month, Day, Year)

State Registrar

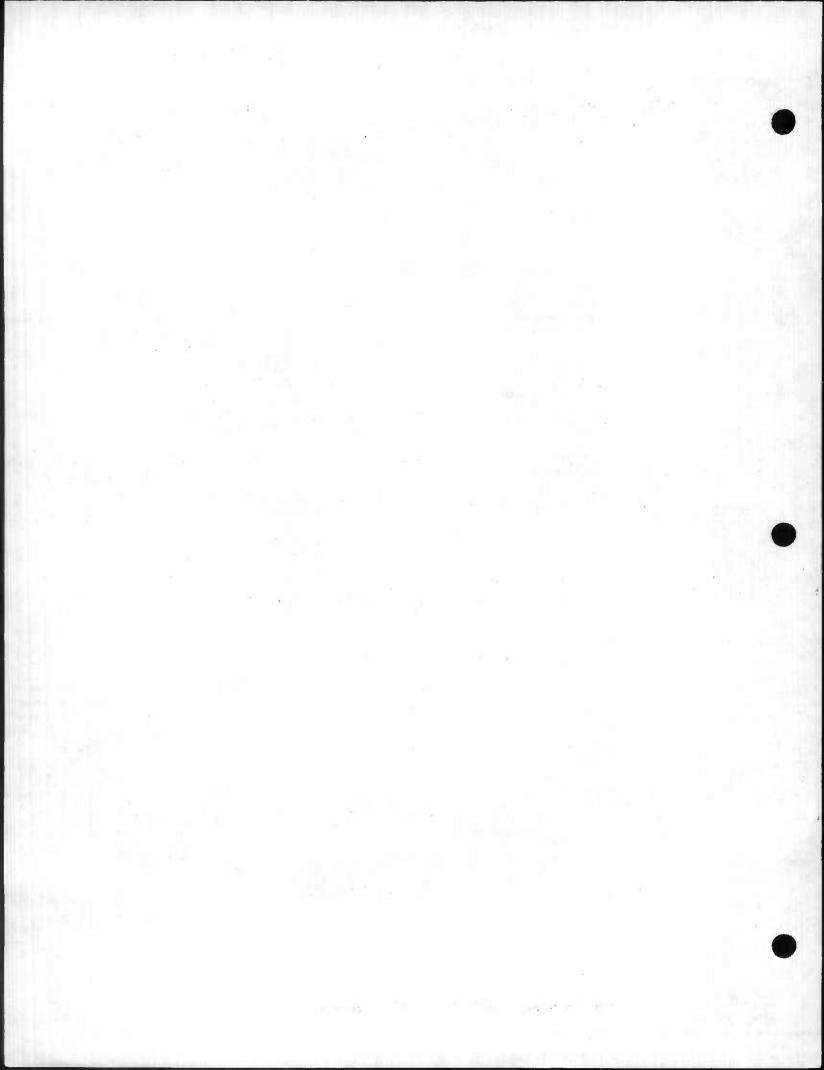
completely

31. Dete tiled (Month, Day, Year) FEB 2 3 1999

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30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) BAPURAD PULLVARTI, Mb 12931 OaKhill Ave, 32. Registrer's Signature

Hagerstoun Md 21742



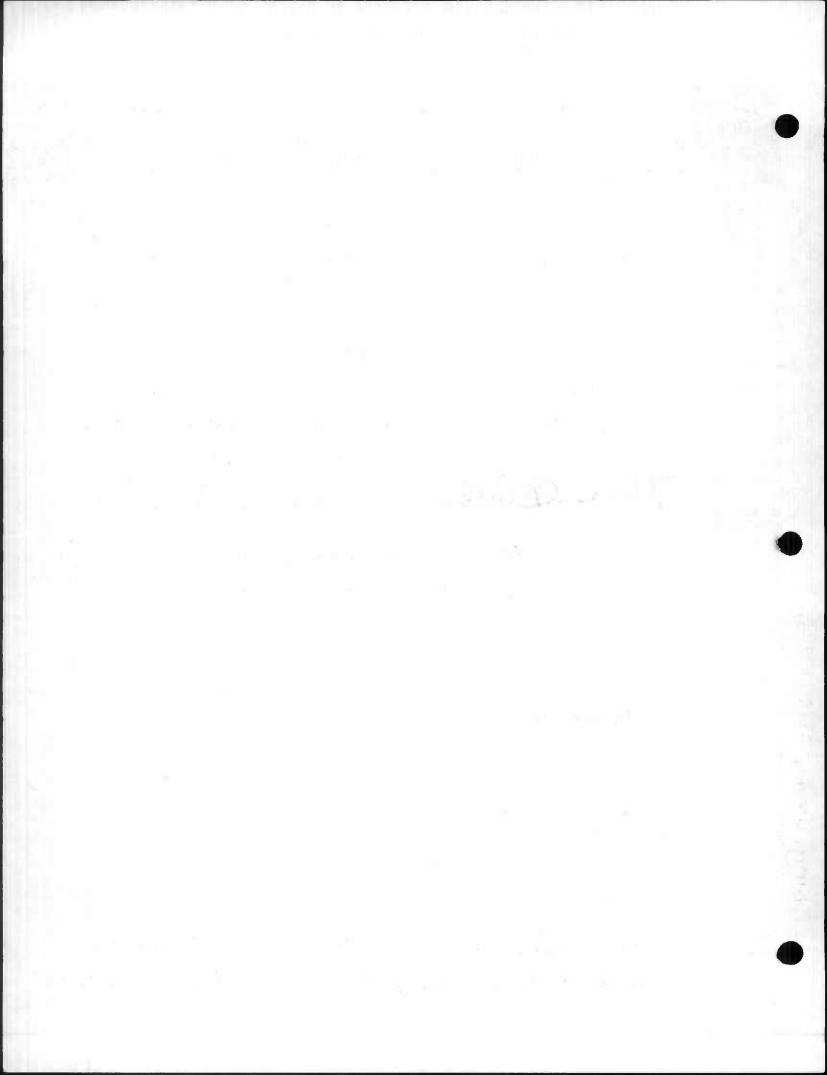
State of Maryland / Department of Health and Mental Hygiene Q

			Certificate of	f Death	Re	ig. No.	1230
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Physician /Modica		MARIE	KAYE		FEB.	24, 1999	4:05 AM
/Medica Examine	do Contitue blome /// and Institution when	street and number)		4b. City, Town, or L	ocation of Death	4c. County of Death	
	WASHINGTON AD	VENTIST HOSPI	TAL	TAKOMA F	PARK	MONTG	OMERY
Funeral	5. Social Security Number 6. Sex	The office	Months De		8. Dete of Birth (Month, Dey,	Year) 9. Birth	place (Stete or Foreign intry)
Director	107-14-2737	M 201F 84	Yrs.		SEPT.23	1,1914	PÁ.
2	Usuel Residence of Decedent 10a. Stete 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
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of the Ma	MD. PRINCE G	EUNUES	10f. Zip Cod		11	og. Citizen of What Cou	inin/?
			1029 000				,,
ther death or them 23 nicher mast	7300 MANDAN R	12. Was Decedent Ever in U,	S. 13. Was Decedent of	20770 f Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No-	U.S.A.	ican Indien,
at a miner	1 Never Merried 2 Merried	Armed Forces? 1 ☐ Yes 2 ☐XNo			Rican, etc.)	Bleck, White	, etc.
F. F. S		If Yes, Give Year or Detes:	1□ Yes 2∭ N	lo Specify:		Specify:	WHITE
led within 72 hours at tygiene. her than "natural" or it, the Medical Exami	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Usuel Oct	cupation ne during most of work	cina	16b. Kind of Business/Ir	ndustry
Lieu and	Elementery/Secondary (0-12)	Cotlege (1-4or 5+)	life. DO NOT use ret	ired)			
A Parent	12		DESIGNE	R/OWNER		FLOWER	SHOP
dibe file	17. Father's Neme (First, Middle, Last)			18. Mother's Nem	e (First, Middle, N		
anyia should and Men marks umarks	2211 32	WATKINS			BAE	COX	
M 2 st 12 st 18 m 18 m	19a. Informent's Neme/Reletionship (Type		19b. Meiling Address (Stre		ral Route Number,	City or Town, Stele, Zi	p Code)
Tank Tank	ANTHONY J. KAY 20e. Method of Disposition	E/HUSBAND	SAME AS I	TEM #10	Dete	20c. Location - City or T	own State
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day of the Paris	4 Donetion 5 Other (Specify)		RYLAND VETERA		RY 3/1/99	CHELTENH	AM, MD.
B B B B B B B B B B B B B B B B B B B	21. Signature of Funeral Service License	10	22. Name and Ad				
	N.M. Cha	nerse MOC	091 CHAMBERS	FUNERAL H	IOMES, P.A	., RIVERDA	LE, MD.2073
	23a. Pert1. Enter the disease, or compli- shock, or heert leilure. List only on	e cause on each line.	n. Do not enter the mode of o	lying, such es cardiec	or respiretory erre	est,	Approximate Interval Between Onset and Deeth
Physician /Medical	Immediate Cause (Finel						011001 2110 00011
Examiner	disease or condition resulting in deeth)	Sepsu	3				
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executed in and ital-transit		. Icespora	my just	mercy		1	
n and ial-fra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	B. J. (r és a consequence of):	de	pathe		
rificate be executed ng physician and as the burial-transit	Cause (Diseese or injury that initieted events	Due to (or	r es e consequence of):	ercang		7	
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		~			24a. Wes en	ned? a	Vere eutopsy findings vailable prior to
. >						0	ompletion of cause of deeth?
The law requir					1 □ Ye	s 240 No 1	☐ Yes 2☐ No
Physician: The la r this certificate has aral director, page 2	25. Wes case referred to medical			28. Place of Dee	th (Check only on	e)	
Physician: rthis certific and director,	1 Yes 2 No	lospitel: 1 Inpatient 2 I	ER/Outpatient 3□ DOA	Other-		nca 6 Other (Spec	sify)
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or Attending P after death. Director: After the funer of in by the funer.	3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specify	ome, ferm, street, lactory, office	00	28f. Location (St. City or Town	reet and Number or Ru	ral Route Number,
tal or Attending P is after death. al Director: After led in by the funerical cartification:							
To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Cer		ician: To the best of my know	wledge, death occurred et the				
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To the Total	29b. Signeture and title of certifier		29c. Lici	ense number	2	9d. Date signed (Month	Day, Year)
5	1 X X A THE			41089		2/24/9	1/
100 700	30. Nems and address of person who co	mpleted cause of death (Item	23a) (Type, Printly / DK	FERNASI	0 4APG	TINA MA	DK MAN
	Washington	Adwards	Hopital,	1600 (81	roll to	reve. la Kard	: Vork pel)
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Registrar	FEB 2.5 1999	Bereva	El. Ana. V.	1			

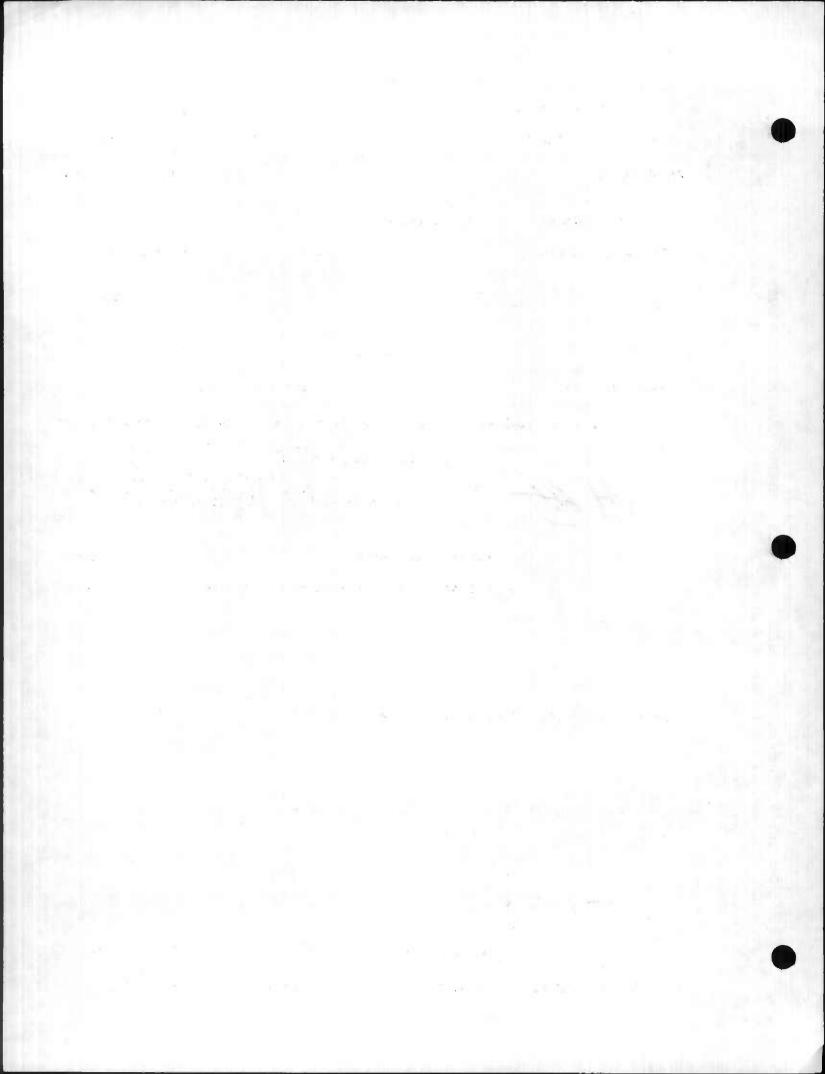
DHMH 16 Rev 6/95

Co. 1

		1. Decedent's Name (First, Middle, Las)					2. Dete of De	eth		3. Time of Deeth
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uneral		Suburban Hospital 5. Sociel Security Number 6. Se	x 7. Age	e (In yrs. lest birtho	(ay) If Under		If Under 24 H	rs. 8. Date of Bir		e gome	
irector		577-74-6501	JM 2⊠F	85 Yr	Months.	Deys	Hours Mi	in. (Month, Da		Wasi	piece (State or Foreign stry) nington, DC
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	Director			Washir	igton,						1 X Yes 2 No
	Die	10e. Street end Number			10f. Zip				10g. Citizen of		
		4821 Woodway Lane				2001			United		
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	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	lo	1□ Yes	2 🖾 No	Specify:		Specify	y:	
		15. Decedent's Edu	Yeer or Detes:	160 D	nondent's Heu	al Coou	nation		10h Vind of D		nite
	Completed	(Specify only highest grad	le completed)	(C	Rive kind of wo	ork done	petion during most of world)	vorking	16b. Kind of B	usiness/inc	austry
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		17. Fether's Neme (First, Middle, Last)			nousew	110	18. Mother's N	ame (First, Middle,			- 12
	To Be	Edward W	arren Bur	cch				Effie	Co	oke	
	-	19a. Informent's Neme/Reletionship (T)			leiling Address	s (Stree	t and Number or	Rural Route Numb			Code)
		Martha King/Daugh	ter					W., Wash:			
	1	20a. Method of Disposition		20b. Plece of D	isposition (Nar	me of		Dete	20c. Location		
0		1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)			crematory or o			2/22/00	C#1	C	~ MD
- C		21- Signature of Funeral Service Licens		Gate of				2/22/99 DeVol Fun			g, MD.
important: if item 27 is eny injury or other tra		Mh. C	NO.8	0			1				
		23a, Pert1. Enter the disease, or comp	ications that caused	the death. Do not	10 East	t De	er Park	Dr., Gai	thersbu	rg, M	D. 20877 Approximete
cian		23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only o	ne ceuse on each line	ө.	011101 1170 11100	so or ay.	g, 00011 00 0010	ac or rospirotory o			Intervel Between Onset end Death
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of ber	SICI	Pert II. Other significent conditions co	ntributing to death but	t not resulting in th	e underlying o	ause di	ven in Pert I.	23b, Did	tobacco use co	ntribute to	the cause of death?
detached	Physician/Med		sice H	_		_		1 🗆	Yes 2 No	3 Prot	bably 4 Unknown
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should								24a. Wes	en eutopsy	24b. We	ere eutopsy findings elleble prior to
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page	E O							10	Yes 2 No	10	Yes 2□ No
	Be	25. Wes case referred to medical					26. Plece of D	eeth (Check only o	nne)	1	
direct	70	examiner?	lospital:	nt 2 ER/Outpe	etlent 3 DC	DA Oti	hor:	Home 5 ☐ Resi		er (Specifi	v)
<u></u>		27. Manner of Deeth	28e. Date of Injury (Month, Day		e of 2	28c. Inju Wo			now injury occur		·
the funer	atio	1 Neturel 5 Pending investigation	(Monan, Day	roar/ Itiju	M		Yes 2 □ No				
6	Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Inju	ry - At home, ferm . (Specify)	, street, factor	y, office		28f. Location (Street and Numb	er or Rura	I Route Number,
8	Ce	Tomoros	building, etc.	. (Specify)				City of 101	vii, State)		
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completely filled		29b. Signeture and title of cartifier	/				se number		29d. Date signe		
		Hani lu (Eunes . P.	2.0.	1	20	6019		te6 19	1, 69	779
- 1	-	30. Neme and eddress of person who co		eth (Item 23e) (Ty	pe, Print)			. /	,		
		11	NER M.S	7. 545	4W:	sco	nsin a	hz Cheu	y Chase	no	20315

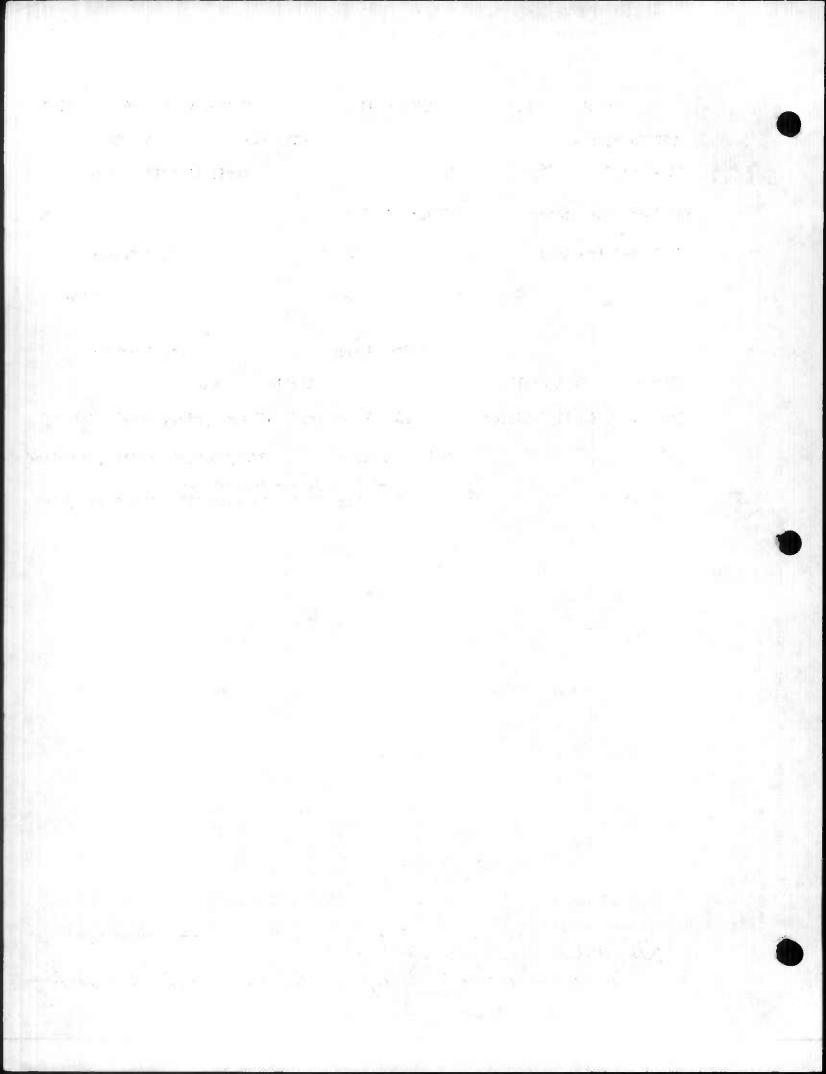


		and the same	Ce	rtificate	of De	eath		Reg. No.			
	1. Decedent's Name (First, Middle, L.	est)					2. Date of D	eath		3. Time of Death	
Physician	Ann Eliza	beth Kobylski					Februa	ary 22,	1999	7:45 PM	
/Medical Examiner	4a Facility Name (If not institution, gi				4b. 0	City, Town, o	r Location of Dea				
ZAGIIIIICI	Rockville Nursin	ng Home			R	ockvil	lle	Montg	omery	7	
Funeral	5. Social Security Number 6.	Sax 7. Aga (In y	rs. last birthday,	If Under 1		Under 24 Hr		rth	9. Birthp	lace (State or Foreign	
Director	218-58-6751	1□ M 2☑ F 9	O Yrs.	Months E	Days F	lours Mir	May 8,			yland	
٥ >	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or L							0d. Insida City Limits	
show										1 ☐ Yas 2 ☑ No	
the Man r 28a-1sh noutled	Maryland Montgor	nery	Rockvil:	1					10.0		
5-0020 72 hours after death with the Maryland natural; or items 23a or 28a-1 show seel Exercited and Edd by Funeral Director	15017 Westbury Ro	ad		10f. Zip Co	2085.	3		10g. Citizen of What Country? United States			
rems Rems	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13.	Was Deceden	t of Hispa Cuban, M	nic Origin? ((Specify Yas or N erto Ricen, etc.)	o- 14. Rad	ca - Americ		
Maryland 21215-0020 d 2 should be filed within 72 hours after the and Mentel Hygiene. T is marked other than "nature!", or in traumatic event, the Medical Exercitor To Be Completed by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates:		1 ☐ Yes 2 ☑					Specify: White		
1 21215-00) ed within 72 hours ygiene. nor than "natural" it, in "deel Ex	15. Decedent's E (Specify only highest gi	ducation	16a. Dece	dant's Usual C	Occupation	n na most of w	rorkina	16b. Kind of B	usiness/In	dustry	
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Maryla d 2 should th end Mer T is merke traumatic	19a. informant's Name/Ralationship						Rural Routa Numi				
	Elaine A. Reeder/Daughter 20a. Method of Disposition 1										
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timent tant:	4 Donation 5 Other (Special	(hy) G	ardens	of Fai	th Ce	emeter	Maryland bert A. Pumphrey Funeral				
Baltimo permit. Peges Depertment of Important: If i	21. Signature of Funeral Service Lice	MO112	26 R	ockvil1	e. T	nc	bert A. 300 West ad 20850	Montgom	y Fun	venue,	
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/Medical	Immediata Causa (Final disease or condition	Myocardia	1 Info	ction						Sudden	
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Box eath cert ettendin for use		0.									
O. E. ne dear the et th	Part II. Other significant conditiona	n Part I.	23b. Dlo	tobacco uae co	entribute to	o the cause of death					
4 year	Chronic Obstructive Pulmonary Disease						10	Yas 2 No	3 ☐ Pro	bably 4 Unknow	
	Cironic obstruct	.ive ruimonary	DISEAS	se			-				
Vital Records, stetan: The law requires th certificate has been signe irector, page 2 should be do Be Completed by								s an autopsy lormed?	av	ere autopsy findings ailable prior to	
Recipient of the second of the									of	mpletion of ceuse daath?	
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f Vital I ystelan: The s certificate director, pag	25. Was cese rafarrad to medical examiner?				20	5. Placa of D	aath (Check only	ona)			
Of Vita Physician: this certific ral director. To Be	1 ☐ Yas 2 ☒ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Othar:	4 🖾 Nursing	Home 5 Res	sidence 8 🗆 Oti	ner (Specia	(y)	
Division of or Attending Physical or Attending Physical Director: After this Jin by the funeral disease ertification: To	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Data of Injury (Month, Day Yaar	28b. Tima o Injury	of 28c	. Injury at Work?		28d. Describe	how injury occu	rred		
Division of the or attending P as effer death. al Director: After the in by the funeral in by the funeral Certification:	2 ☐ Accidant Investigation			M	1 Yas	2 □ No					
ivigination in the state of the	3 Suicide 6 Could not in determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st	reet, factory, o	office		28f. Location City or To	(Street and Num own, State)	ber or Run	al Routa Number,	
Ce de De											
Divisor To the Hospital or Atterwishin 24 hours efter defect To the Funeral Direct completely filled in by the Medical Certific		hysician: To the best of my iminer: On the basis of exam									
Vithin To the complex of the Me	29b. Signature and title of certifier	V		29c. L	icense nu	umber		29d. Date sign	ed (Month,	Day, Year)	
	10	\sim	M		D074	71		Februa	rv 23	, 1999	
	30. Name and address of person who	commented cause of death /	tem 23a) /Turns						-, 20		
	Paul T. Noone, M.				77.0	Dool	110 16-	evilond o	0050		
State	31. Data filed (Month, Day, Year)	32. Registrar's Sk		-			lle, Man	yrand 2	0032		
Registrar		199 Sener		ppo	uls	/					



State of Maryland / Department of Health and Mental Hygiene 9 9 0 7 2 4

					(Certific	ate of	Death		Reg. No.	J	1641	
Physician	-	1. Decedent's Neme (First, Middle, La	st)	117		197			2. Dete of D		Yeer	3. Time of Deet	
/Medical	1	JUNIOR	L.		KUYI	KENDAL	L		FEBRUA	RY 24,1	999	6:05 PI	
Examiner		4e. Fecility Neme (If not institution, giv LORIEN NURSING)				4b. City, Town, or COLUME	BIA		ty of Deeth OWARD		
Funeral Director		5. Social Security Number 6. S 216-10-9006	Sex 7. Ag	ge (In yrs. 81	lest birthi Yr	Mont	hs Days	H Under 24 Hrs Hours Min	8. Date of B (Month, D April	irth Pey, Year) 12 1917	Cour	plece (State or Forentry) nessee	
f show	1	106. Stete 10b. County Maryland Montgome	ery		y, Town o	or Location Spr	ing				1	0d. Inside City Lim	
3a or 28a	2010	10e. Street end Number 2625 Bel Pre Roa	ad			10f.	Zip Code 2090	6		10g. Citizen of		•	
natural, or items 23a or 28a-f show ad cal Examination collisis at the collisi	2	11. Maritel Stetus 1 □ Never Married 2 □ Merried 3 □ Widowed 4 ☑ Divorced	12. Was Decadent Armed Forces? 1 XYes 2 If Yes, Give Year or Dates:	7			ecedent of I specify Cub	Hispenic Origin? (sen, Mexican, Puer Specify:	Specify Yes or N rto Ricen, etc.)		ce - Americ ack, White,	an Indien,	
	pleter	15. Decedent's Ed (Specify only highest grade) Elementery/Secondery (0-12)	flucation de completed) College (1-4or	5+1	16e. D	ecedent's U Give kind of fe. DO NO	Isuel Occup work done Tuse retire	pation during most of wo d)	orking	16b. Kind of E	Business/Ind	dustry	
ther than		7	0	54)	Br	ick 1	ayer			Const	ructi	on	
T is marked other traumatic event, I	0	17. Fether's Neme (First, Middle, Last, Clarence Kuyke	endall					18. Mother's Ne Stella		e (First, Middle, Melden Surname) Ma xe y			
- E			19e. Informent's Neme/Relationship (Imo gene K. Beall						Road, S				nd 20906
nt: If item 27	1	20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specification)				isposition (cremetory)			Dete 2/27/99	20c. Location		wn, Stete , Marylai	
Important: If ite any injury or of once.		21. Signature of Funeral Servica Licer		2	111	22. Name Muri	end Addre	Barber	Funeral	Home			
43		23a. Pert1. Enter the disease, or com, shock, or heart feilure. List only	N - 03	acco		P.O.	Box	5038, 1	aytons	ille, M	aryla	nd 2088 Approximete	
siclan and buriel-transit buriel-transit	th	Sequentielly list conditions, if ony, leeding to Immediate seuse. Enter Underlying Couse (Disease or Injury that initiated events	b. Covers	Due to (o	r es e cor	sequence nsequence	ofic Rld coops We	idial sclevo:	sis -		/	Recens	
ing physe as the		thet initiated events resulting in death) Lest	d	Due to (or	es e con	onsequence of):				·	0		
ed for us	F	ert II. Other significant conditions of	ontributing to death b	ut not resu	alting in th	e underlyin	g ceuse gh	ven in Pert I.	23b. Did	tobacco use co	ontribute to	the cause of dea	
igned by the attend be detached for us by Physician/		COPA								Yes 2□ No	3 X Prot		
should should			- 1							s en eutopsy omed?	eve	ere eutopsy finding eileble prior to mpletion of cause deeth?	
		25. Wes cese referred to medical	V							Yes 20 No	10	Yes 2 No	
il director		examiner?	Hospitel:	nt 2 🗆	ER/Outpa	stiont 2	DOA Oth		eth (Check only		/0/	.1	
5 70	2	7. Menner of Death	28e. Dete of Inju	rv	28b. Tim	e of		y at		Idence 6 □Oti		/)	
al Director: After ted in by the funerical Certification:		1 Neturel 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	(Month, Dey Year) Injury Work? M 1 Yes 2 No				28f. Location (Street end Number or Rural Route Number City or Town, Stete)						
Funer lely fill ical	1	29e. Certifier 1 Certifying Phyone) 2 Medical Exam	reician: To the best of iner: On the basis of and menner sta	examinati	viedge, d	eth occurr r Investiget	ed et the tir	ne, dete end plece pinlon, deeth occu	e, end due to the urred et the time	cause(s) end m	enner es st	ated. the ceuse(s)	
To the comple	2	9b. Signeture end title of certifier	11,00	100	111	61	29c. Licens	e number	-	29d. Dete signe FEBRUAR			
	3	9. Neme end eddress of person who of	ompleted cause of de	eeth (Item	23a) (Ty	pe, Print)	1.00	Roo	51/1, to	OF	1112	5/4/2	
State	3	1. Dete filed (Month, Day, Year)	32. Registre	OCC er's Signet	ure	May	oles	Rel &	Matt	City.	NA	210	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Death Month 3. Time of Death DERWOOD KIMBLE 23, 1999 February 8:35 PM 4a Facility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth 16211 Ash Box Road Brandywine Prince George's 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Data of Birth (Month, Day, Year) Days Months Hours 1 € M 2 □ F Yrs. 220-34-4490 58 AUG 30 1940 W. Virginia Usuel Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16211 Ash Box Road 20613 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Maritei Status 1 Nevar Merried 25 Married Yes 2 No Yes, Give 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 10 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Ira Kimble Clarice Dean Kimble 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Linda R. Kimble (wife) 16211 Ash Box Road Brandywine, MD 20613 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete MBuriel 2 Cremetion 3 Removel from State 5 Other (Specify) Trinity Memorial Cem. 2-27-99 Waldorf, MD 21. Signatur une Al Service Licenses 22. Name end Address of Fecility M00173 J.H. Eberwein Mortuary den 4433 White Pls La White Pls., MD 20695 enter the mode of dying, such as cardiac or respiretory errest, nter the disease, or complications that caused the death. Do not enter heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediete Cause (Finel

Physician /Medical Examiner

> buriel-tran and physician the burie

> > USB

the signed by

Physician

/Medical

Examiner

10a. State

Director

Funeral

Be Completed by

Funeral

Director

Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

disease or condition resulting in deeth)	a	0	1 P CHZ		
resulting in death)	Due to (d	or es e consequence d	ŋ:		1
Sequantially list conditions, if any, leeding to immediate cause. Enter Undarlying	b. Due to (c	or es e consequence o	n):		
Cause (Diseesa or injury that initieted events resulting in death) Last	cDua to (c	r as a consequence o):	lan in the second	
Part II. Other algnificant conditions co	d.	ulting in the underlying	cause given in Pert i.	23b. Did tobacco use co	ntribute to the cause of death?
				24a. Wes en eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death? 1 □ Yes 2 □ No
25. Wes case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatiant 2 I	ER/Outpatient 3	Othor	Homa 5 N Residence 6 □Oth	er (Specify)
-X		28b. Time of	28c. Injury at	28d. Describe how injury occur	red
27. Menner of Death 1 Neturel 5 Panding 2 Accident invastigation	28e. Dete of Injury (Month, Dey Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No		

State Registrar

31. Date filed (Month, Dey, Year) FEB 26 1999

29b. Signeture and title of certifier

015

32. Registrar's Signeture

Mell

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

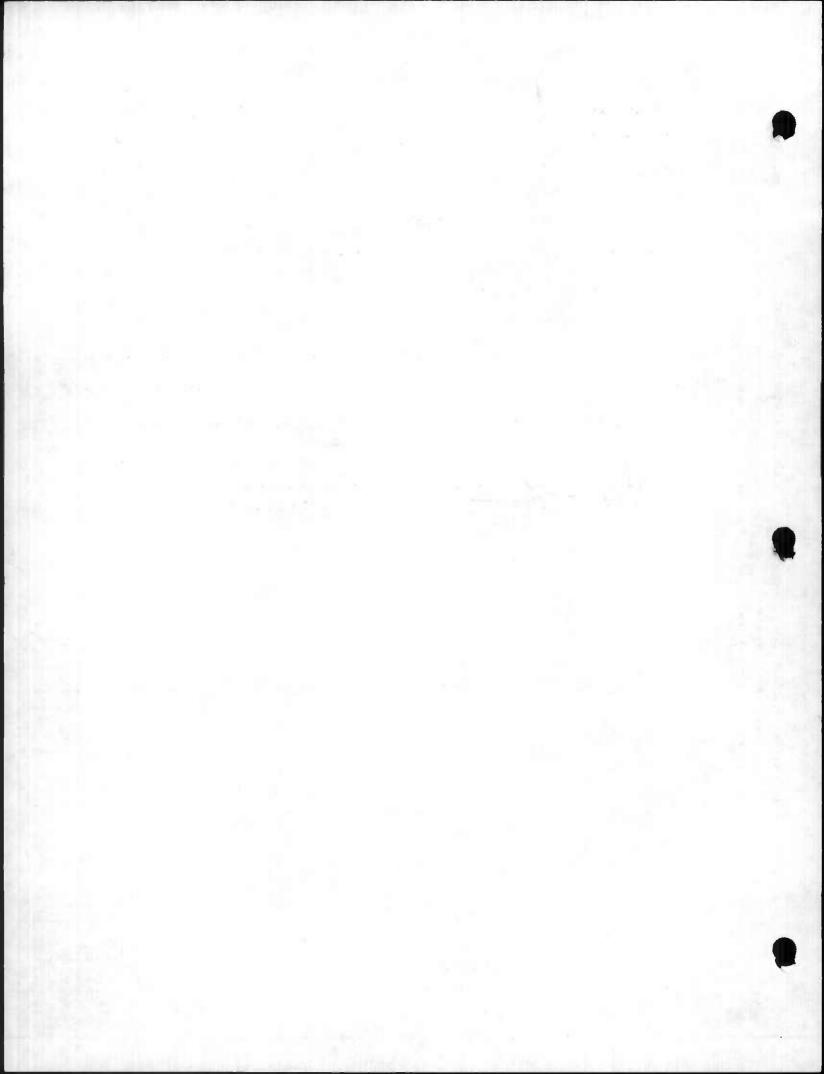
29c. License number

29d. Date signed (Month, Day, Year)

spltat or Attending Physhours after death.

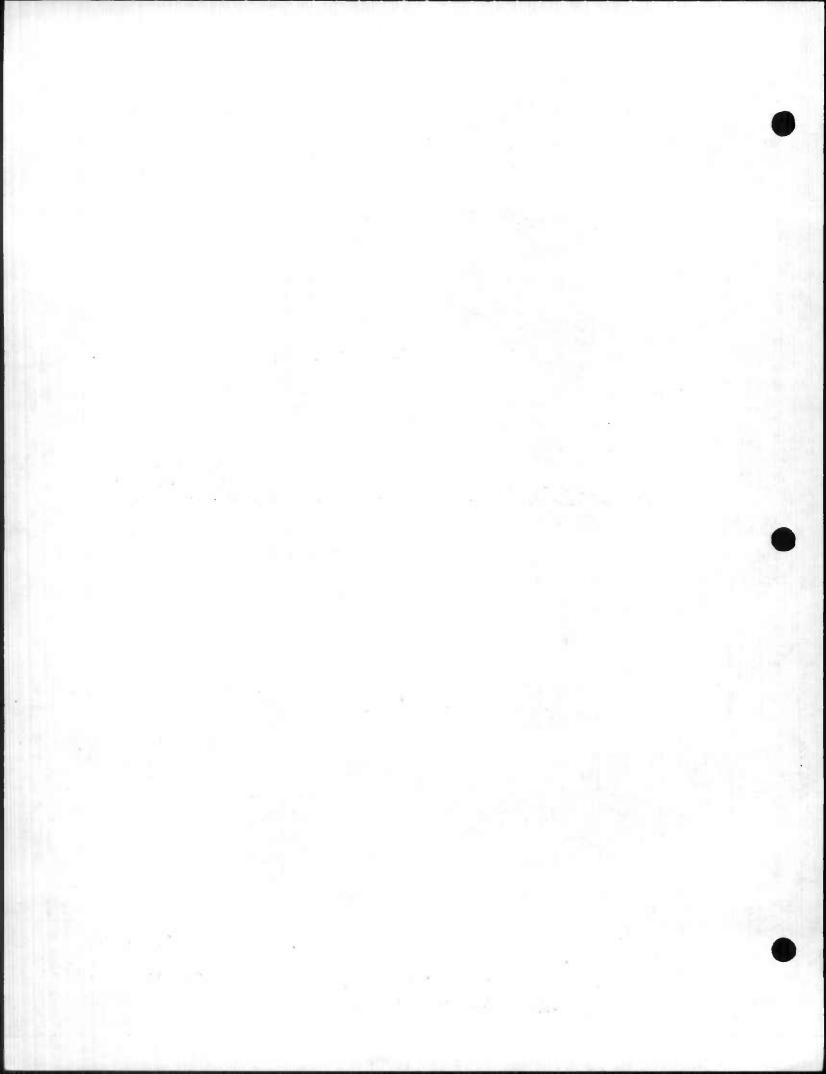
neral Director: After this y filled in by the funeral d

To the Hospital o within 24 hours at To the Funeral Di completely filled is



State of Maryland / Department of Health and Mental Hygieneg 9 0 7 2 4 3

			Certificate of	Death	Reg.	No.	1240
	Decedent'a Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physician /Medica	Barbara Jean LONG	number!		4b. City, Town, or Lo	February ration of Death	Day Year 1990 4c. County of Death	
Examine							
	Washington County Hospi 5. Social Security Number 6. Sex	1tal 7. Age (In yrs. last birt)	hdev) If Under 1 Year	Hagersto	8 Date of Birth	Washingt	
Funeral Director	185-26-4210 Usual Residence of Decedent	1 =	rs. Months Days	Hours Min.	(Month, Dey, Ye Dec 25 1		hplace (Stete or Foreign untry) nnsylvania
death with the Maryland ms 23a or 28s-f show Linest be notified at	10e. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes 2X No
W Series	Pennsylvania Franklin		Greencastl	e			
vith the Mar t or 288-f si	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	untry?
23a	952 Milnor Road		1722			J.S.A.	
020 urs after al', or he	3 ☐ Widowed 4 ☑ Divorced If Yes, 0	s 2 □XNo Give	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
15-002 n 72 hours	15. Decedent's Education	16a.	Decedent's Usual Occup	pation	168	o. Kind of Business/I	ndustry
	(Specify only highest grade completed Elementery/Secondary (0-12) College	(1-4or 5+)	(Give kind of work done life. DO NOT use retired	d) most or working)	79		
d 2121 fled within Hygiene. ther then end, me the	11 0		Seamstress			Jacket Mf	íg.
Baltimore, Maryland 2121 pernit. Pages 1 and 2 should be flied within Department of Health and Mental Hygiene. Important: if item 27 is merked other than any injury or other traumatic event, the Hygiele. To Be Commi				18. Mother's Neme	(First, Middle, Mail	den Sumeme)	
Via Went Ment	Homer E. Lloyd			Emma B.	Rumme1		
S sho a man a mum	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street	end Number or Rura	l Route Number, C	ity or Town, Stete, Z	ip Code)
M . Malth	Tracy Lynn - Granddaugh		5 W. Wilson		agerstown	n, Marylar	nd 21740
of He oth	20a. Method of Disposition	20b. Place of cemeters	Disposition (Neme of y, cremetory or other plea	ce)	Date 200	. Location - City or 1	Fown, State
Page Page vy or	1 🖾 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	11 State	Haven Cemet		/22/99 H	Jagerstown	n, Maryland
Baltimore, semit. Pages 1 at Separtment of Hea mortant: if terming in July or other MEE.	21. Signature d Emeral Service Licensee	24 "	22. Name and Addre			neral Home	
W SOF S	SCHIM	1/1	5 E. Wil				
	23a Part 1 Enter the disease or complications that	caused the death. Do n	1				Approximate
Physician //Medical	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on immediate Cause (Final		Interval Between Onset and Death				
Examiner	disease or condition resulting in death) a.	Due to (or as a c	1	wzus		1	12093
3), assouted assouted in and rial-transit	Sequentielly list conditions.	Due to (or as a c	onsequence of):				
68760, ficate be assected physician and is the burial-transit	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events.	D-14 (
	resulting in death) Last	Due to (or as a co	onsequence or):				
Box Beth cer attendin for use							
P.O. Box at the deeth certification of the attending etached for use a Physician A.	Part II. Other algnificant conditions contributing to	1	6	en in Part I.	23b. Did toba		to the cause of death
) 5 20 .		Lung >	てらってい		1 Yes	2 G-N6 3 Pr	robably 4 Unknow
Z S S S S S S S S S S S S S S S S S S S					24a. Was en e performed	d? a	Were autopsy findings available prior to completion of cause of death?
I Rec The law ate has b page 2 s	District Control of the Control of t				1 ☐ Yes	2 No 1	1 ☐ Yes 2 ☐ No
Vital I Vital I Lician: The certificate rector, page Co	25. Was case referred to medical			26. Place of Deeth	(Check only one)		
	Hospital:	Inpatient 2 □ ER/Out	patient 3 DOA Oth	ner: 4 Nursing Hor	ne 5 Residenc	e 6 Other (Spec	cify)
0 4 43	27. Manner of Death 28a. Date	e of Injury onth, Dey Year) 28b. To		y at 2	28d. Describe how	injury occurred	
Vision Attending I Acted to the fune	1 ☑Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	milit, Doy real)		Yes 2□No			
	3 Suicide 6 Could not be determined 28e. Place	ce of Injury - At home, far ding, etc. (Specify)	m, street, factory, office	4	28f. Location (Street City or Town, S	et and Number or Ru Stete)	ral Route Number,
Di Di To the Hospital or within 24 hours aft To the Funeral Dir completely filled in Medical Ceri	29a. Certifier (Check only one) 1 Certifying Physician: To the one) 2 Medical Examiner: On the	ne best of my knowledge, basis of examination and inner stated.	death occurred at the tir Vor investigation, in my o	ne, date and place, a pinion, deeth occurre	and due to the caused at the time, date	e(s) and manner as and piece, and due	stated. to the cause(s)
Med Med	29b. Signature and title of certifier		29c. Licens	e number	29d	Date signed (Month	Day, Year)
● ₹₹8	10 mg (11))	104	1786		2/18/	99
	30. Name and address of person who completed car	use of death (Item 23a) (Type, Print)	hill ave	Hoge	BSTREEN, MI	21742
State		Registrar's Signature	B. Some	61	/ /		



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15 Clarence E. Larson Feb. 8:00 P. M /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
Sept. 20, 1909 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 180 M 2□ F 89 Minnesota 573-22-0762 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Bethesda 1X Yes 2 □ No Director 288-1 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? b 20817 USA 6514 Bradley Blvd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11 Marital Status Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 b 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Year or Detes: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+)
5 + Elementery/Secondery (0-12) Chemist Union Carbide 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Louis L. Larson Caroline Ullman 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health as Important: if Item 27 is any injury or other trax Bethesda, MD 20817 6514 Bradley Blvd. Jane W. Larson -Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 2/19/99 Balt. - Wash. Crematory Laurel, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Joseph Gawler's Sons 21. Signeture of Funeral Service Licensee Washington, D. C. 20016 5130 WI Ave. N. W. W Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, pyrieert feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** tmmediete Ceuse (Finel disease or condition resulting in death) /Medical aspiration preuponica
Due to (or es e consequence of): one week Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial Physician/Medical L months 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 10 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attanding Physician: 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident after deat Director: 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide ò To the Hospital of within 24 hours at To the Funeral D Completely filled in 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as steted. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1734968 VIL DO MID Feb. 16, 1899 0 0 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 9707 Medical center Dr. Suite 320, Ruckville, MD 20150 H. Victor Chiang min

Registrar

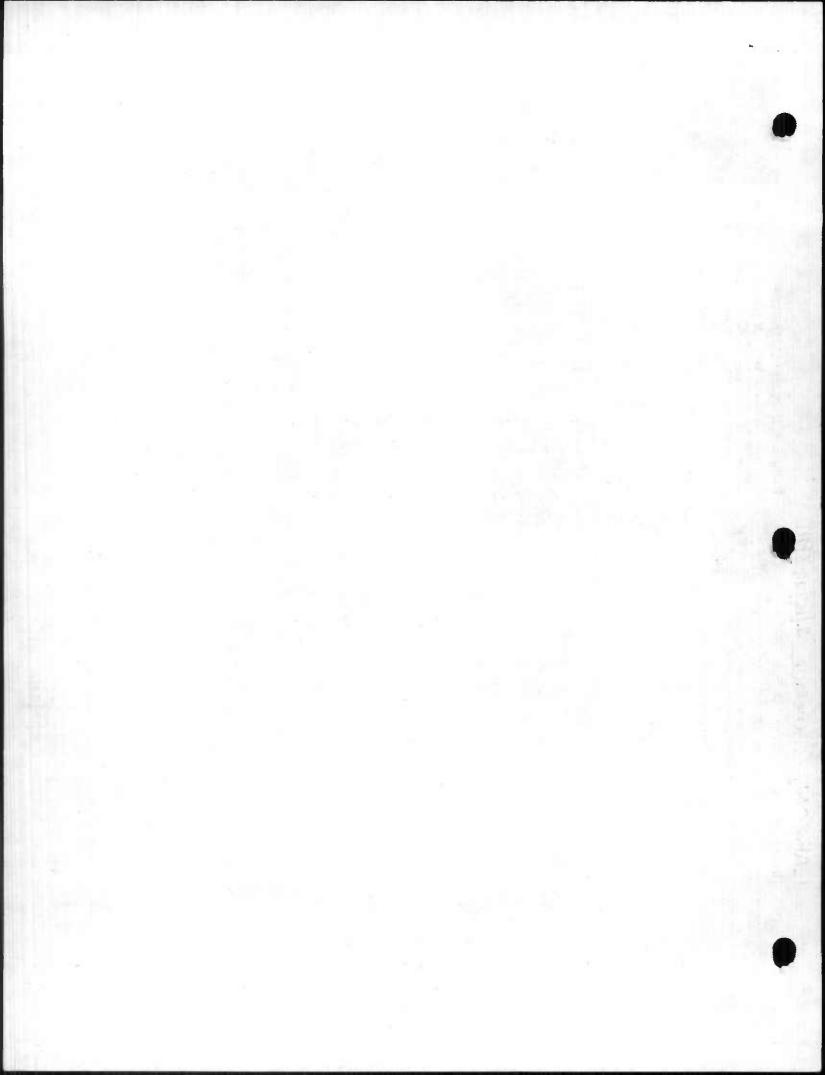
31. Date filed (Month, Dey, Year)

FEB 22

- larence 2/15/998PM

ARSON

32. Registrer's Signeture



nt in Black indelible ink. Assure All C	
aryland / Department of Health and Mer	ntal Hygiene 9 0724
Certificate of Death	Reg. No.

	L
Physician	ľ
/Medical	ŀ
Examiner	ľ
	1

Funera Directo

pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Event we must be notified.

Baltimore, Maryland 21215-0020

Physician /Medical Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completally filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

1. Decedant's Neme (First, Middle, Last) 2. Data of Deat Month										Yea	3. Tima of De	
	G	ail M.	Laffert	У				Februa	rv 23	, 199		
4a Facility Nama (If	not Institution, g	iva street and n	um <i>ber)</i>			4b. City, T	own, or L	ocation of Deet	-	ounty of De		
Maplewood	d Park P	lace				Beth	esda		Mo	ntgom	erv	
5. Social Security Nu		Sax	7. Aga (In yrs	. last birthday)	If Undar 1 Ye	aar If Unda	r 24 Hrs.	8. Data of Bir (Month, Da			9. Birthplaca (Stata or Fo	
566-44-93	27	1□ M 2☑ F	[™] 2× F 95		Yrs. Months De		Min.	Nov. 18	3. 190	3 Mi	Michigan	
Usual Rasidence of I							1					
10a. Stata	10b. County		10c. C	ity, Town or Loc	ation						10d. Inside City I	
Maryland	Montgom	nery		Bethe	sda						1 🗆 Yes 2	
10e. Street and Num	ber				10f. Zip Coo	de			10g. Citize	n of What (Country?	
9707 01d	Georget	own Roa	d		20	814		1000	Unit	ed Sta	ates	
11. Marital Status		12. Was Dad	cadant Ever in I	ant Ever in U,S. 13. Was Dacedant of			of Hispanic Orlgin? (Specify Yas or No Luben, Mexicen, Puerto Rican, atc.)			. Raca - An	narican Indian,	
1 Nevar Marria	d 2 Married		2 No	Vo								
3 ⊠ Widowed 4	4 ☐ Divorced	If Yas, G Yeer or I		1 ☐ Yas 2 ☑ No			<i>/</i> :		S	pecify:	Thite	
(0	1)	16a. Decedent's Usual Occupation			at of war	line	16b. Kind	of Busines	ss/Industry			
(Specify only highast grada completed) Elementary/Secondary (0-12) College (1-				(Giva kind of work dona lifa. DO NOT usa retire			na during most of working ired)			Coun	ty	
	, (5 12)	4		Teacher					Pub1	ic Scl	hoo1s	
17. Father's Neme (F						18. Moth	ner's Nam	na (First, Middle	, Maidan S	umama)		
Clyde Bettinghouse					ce M	cKinnon						
19a. Informant's Nar	ma/Ralationship	(Typa, Print)		19b. Mailing	g Addrass (St	reet and Num	ber or Ru	ral Route Numb	per, City or 1	Town, Stata	, Zip Coda)	
Richard C.	Laffer	tv/Son		10021	Penfo1	d Cour	t. P	otomac,	Marv	land	20854	
20e. Mathod of Dispo		cy/ bon	20b.	Diana of Dianas	ition /Alama a			Date			or Town, Stata	
1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata camatary, cramatory or other place) Feb. 25, 1999											Manual and	
4 Donation 5 Othar (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland												
21. Signature of Funeral Sarvice Licansee ROBETT A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805												
* Ray	A Son	~		98 Rob	ert A. 0 West ckvill	Pumph Montg e, Mar	rey omer ylan	Funeral y Avenu d 2085	Home, e 0-280	/ Rock 5	ville, In	
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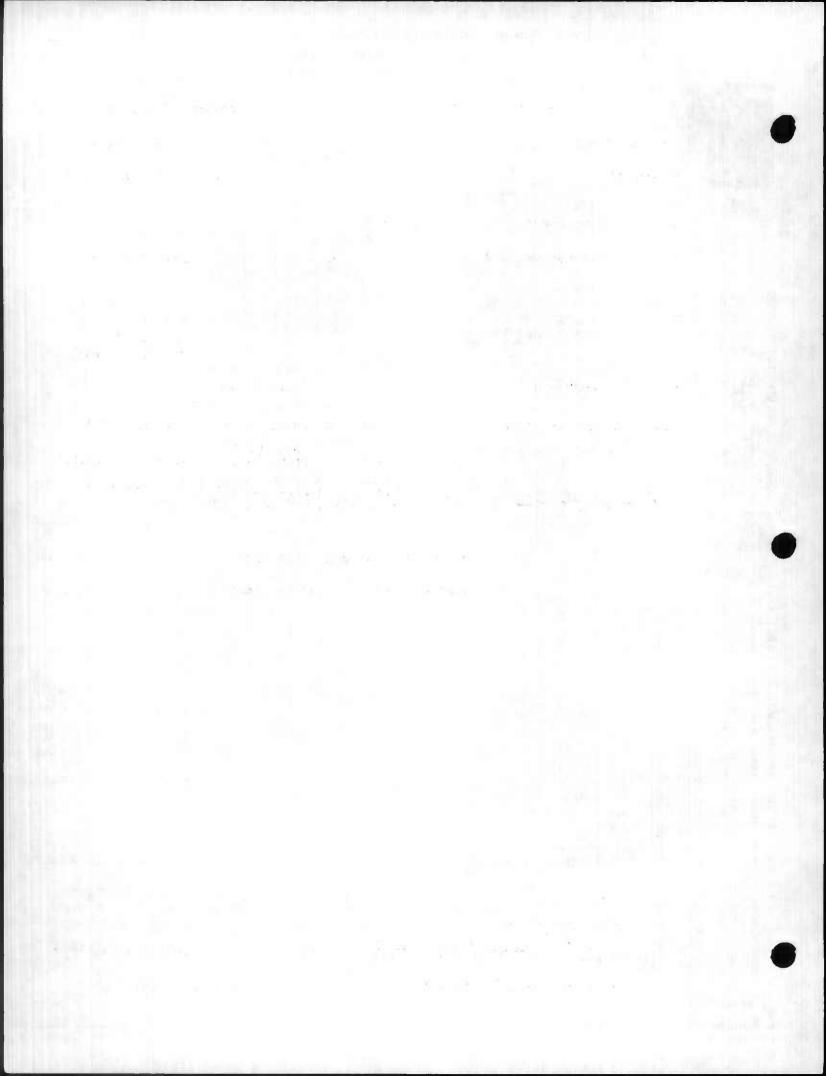
State Registrar

Lee R. Pennington, M.D.

31. Dete filed (Month, Day, Yaar)



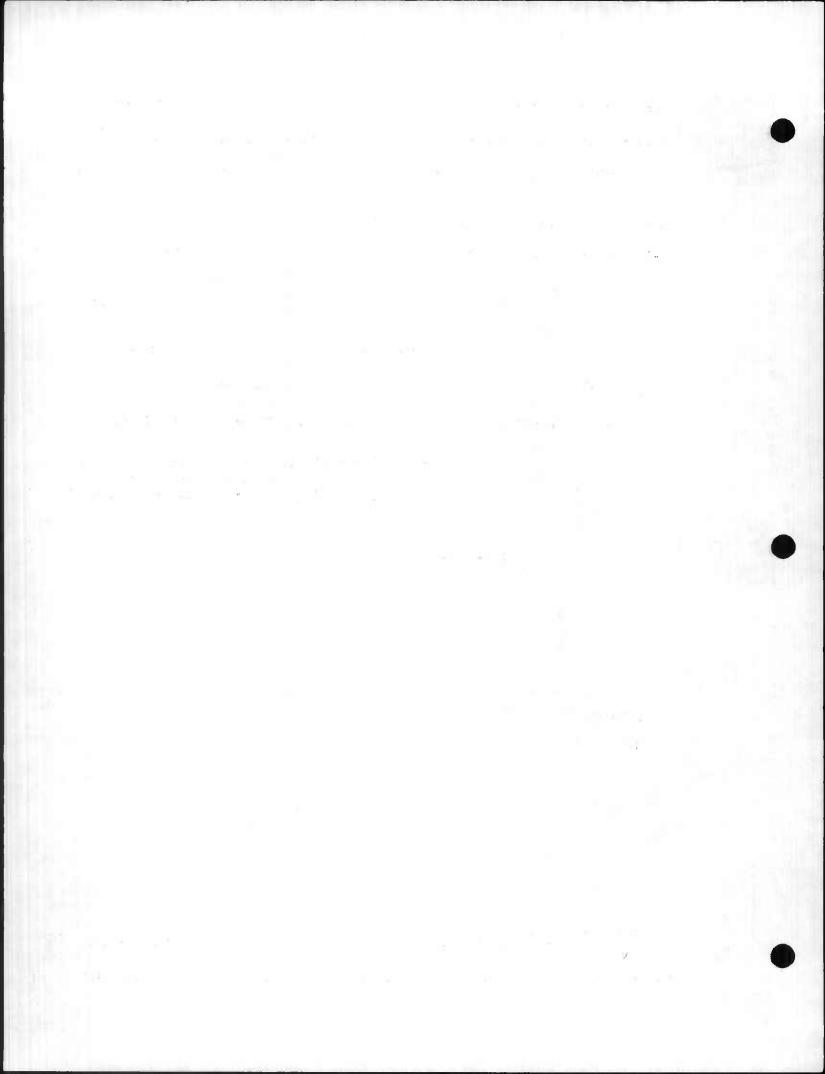
5602 Shields Drive, Bethesda, Maryland 20817



State of Maryland / Department of Health and Mental Hygiene 9 9

	Ce	ertificate of Death	Reg. No.	3 01246		
CHARLET AND	Decedent'a Neme (First, Middle, Last)		2. Data of Death	3. Tima of Deeth		
Physician /Medical	Genevieve W. Landon		February 23,	1999 7:33 AM		
Examiner	4a Fecility Neme (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death 4c. Coun	nty of Death		
	Wilson Health Care Center	Gaithers		tgomery		
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Aga (In yrs. last birthda.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Dete of Birth (Month, Dey, Year) Jan 13, 1910	9. Birthplece (Stete or Foreign Country) New York		
2	Usuel Residence of Decedent			10111100111		
show	10a. Stata 10b. County 10c. City, Town or	Location		10d. Inside City Limits 1 Tyes 2 No		
28ef st	Maryland Montgomery Silver S		10g. Citizen of Whet Country?			
ith the	10e. Street end Number	10f. Zip Coda		f Whet Country?		
rai	15311 Beaverbrook Ct, #2D	20906	USA	and American Indian		
72 hours after deeth with the Marylend natural, or items 23a or 28a-f show stell Examiner must be notified at eted by Funeral Director	11. Meritel Stetus 1 Never Marriad 2 Married 3 Widowed 4 Divorced 12. Wes Decedani Ever In U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	t Was Decedant of Hispenic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Pican, etc.) 14. Fi	ace - American Indian, lack, White, etc.		
ygiene. Ner than "nature tt, tre Medical	15. Decedent's Education 16e. Dec	edent's Usuel Occupetion	16b. Kind of	Business/Industry		
3 5	(Specify only highest grede completed) (Gif Elementery/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	Own Home			
d other than event, prem Be Comp		emaker	Own H	ome		
S SET	17. Fether's Name (First, Middle, Last)	18. Mother's Nem	e (First, Middle, Maiden Sum	Maiden Sumeme) or, City or Town, Stete, Zip Code) ing, MD 20905		
	Frank I. Winant, Sr.	Jennie	Lemon			
d z should th and Mer T ie marke treumatic	19e. Informent's Neme/Reletionship (Type, Print) 19b. Ma	iling Address (Street end Number or Rus	ral Route Number, City or Tow	m, Stete, Zip Code)		
	Ellen L. Mann/Daughter 2016	Mayflower Dr, Sil	ver Spring, M	D 20905		
of Healt of Healt itam 27	20e. Method of Disposition 20b. Place of Dis	position (Neme of emetory or other place)	Dete 20c. Location	n - City or Town, Stete		
y it: ■ Y	# D Burial 2 D Cremetion 3 D Remove from State		Feb 26 Salis	hury MD		
Department on the control of the con	WI TOOMIT	22. Name end Address of Fecility Hin				
Deparation once		1800 New Hampshire				
	23a. Pen1. Entar the disman, o) complications that caused the death. Do not e shock, or heef failure. Ist only one cause on each line.			Approximete Interval Between		
husisian	shock, or heert failure. List only one cause on each line.			Interval Between Onset and Deeth		
hysician /Medical	Immediate Cause (Final disease or condition			2 DAYS		
xaminer	resulting in death)			2011()		
	Due to (or as e cons	equence or):				
an and nel-transit	Sequentielly list conditions. Due to (or es e cons	equence of):				
physician and s the buriel-transit	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disaasa or injury c.	0400100 017.				
physicials the bur	that initiated evants Due to for as a cons	equance of):				
dedi	resulting in deeth) Lest	oquanou ory.				
requires the the bean certificate the secure tention and solution by the attending physician and hould be detached for use as the buriel-transit eted by Physician/Medical Examin	d					
d by the attendireletached for use	Pert II. Other significant conditions contributing to deeth but not resulting in the	underlying cause given in Part I	23h Did tohacco use	contribute to the cause of death?		
signed by the a lid be detached if d by Physic		undenying cause given in Part I.	1 Tos 2 KN			
igned to be detailed by P	RHEUMATUID ARTHRITIS		10100 220,111	, ooaa,		
pis d	DEMENTIA		24a. Wes en eutopsy	24b. Were eutopsy findings		
been s should	DOWEL ILL		performed?	evelleble prior to complation of causa of deeth?		
paga 2 should			1 ☐ Yas 2 KNo			
certificate rector, pag	05 W			TU Tes ZU NO		
s certific director.	25. Wes case referred to medical exeminer?		th (Check only one)	21 22 27 1		
this crail dire	1 I inpatient 2 I EH/Outpet	ient 3LJ DOA 4D Nursing H	ome 5 Residence 6 C			
After	1 Natural 5 Pending (Month, Dey Year) injury					
Attending rinysician: at death. ector: After this certific by the funeral director, iffication: To Be (3 Suicide 6 Could not be 200 Black of lailing. At home farm		28f Location (Street and Nu	m ber or Rural Route Number,		
oline In by	4 ☐ Homicide determined building, etc. (Specify)	street, ractory, ornica	City or Town, State)	moor or rioral riodio riamoor,		
n 24 hours after death. No Funeral Director: After to pletally filled in by the funeral edical Certification:	One Codificate A Condition Discolator To the heat of an instead of the	ath annuared at the time date and alone	and due to the source(a) and	manner on stated		
Fun taly	29a. Certifier (Check only) one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of exemination end/or	eth occurred et the time, date end pieca, investigation, in my opinion, deeth occur	red et the time, date end piac	e, and due to the cause(s)		
within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral Medical Certification: 1	end menner steted. 290. Signature and title of dentifier 1 A	29c. Licensa number	29d Date sin	ned (Month, Dey, Year)		
	THAT IN KINING IND	D31563				
15	Angel Mar Manage Mar	V)1)0)	1 CPFU	ARY 23, 1999		
		e, Print) LOCKWOUD DRIVE	SILVERSPRII	45, MP 20901		
State	31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture	1				
Registrar	FEB 25 1999 Seneva 5	Sporks				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Nama (First, Middle, Last) Feb. 21, Day 1999 **Physician** 4:12pm Car1 Lang /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Pay, Year) Aug. 10, 1904 If Under 1 Yaar If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□ F 94 Yrs. 123-12-2558 Aug. **Director** Usuat Residence of Decedent should be filed within 72 hours after death with the Manylend nd Mental Hygiene. marked other than "natural", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-1 show the Medical Examiner must be notified at XXYas 2 No MD MONTGOMERY SILVER SPRING Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 20904 812 DOWNS DRIVE USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yas ②OXNo If Yes, Give Yaar or Datas: 1 ☐ Naver Married XX Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cottege (1-4or 5+) PLUMBER 2+ PLUMBING INDUSTRY permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic avent, phose. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LIPMAN LANG HANNAH HECHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 DOWNS DR, SILVER SPRING, MD GERALD LANG SON 20b. Place of Disposition (Name of /cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation noval from State 02-23-MT. ARARAT CEMT. PINELAWN, LI, NY 4 Donation 5 Other (Signatore of Fu 22. Name end Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC Enter the disease, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac of respiratory arrest. MD or hoart failure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Gudden Examiner Due to (or es a consequence of) Examiner monia attending physiclen end for use as the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificete hes I funeral director, pege 2 s 2 No 1 Yes 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 27. Magner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: To the Hospital or Attending 5 Pending Investigation 1 Neturel 2 Accident 1 Tyes 2 No deeth. Director: / 8 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 ☐ Homicide efter within 24 hours of To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

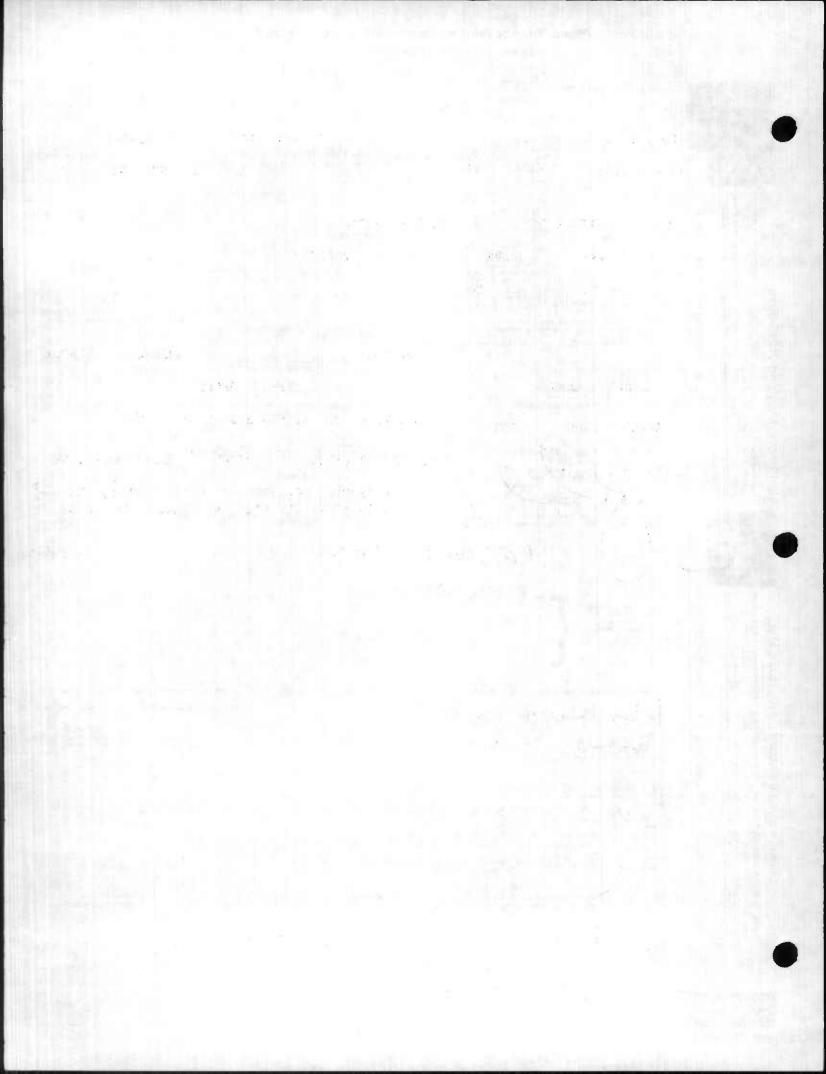
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Spring NU 080

State Registrar

31. Date filad (Month, Day, Year)

FEB 23

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month FEB. 23, 1999 JACK LEEDS 9:54AM 4b. City. Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death 11605 KAREN DRIVE ROCKVILLE MONTGOMERY 6. Sex 12 M 2 □ F If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Yrs. 78 254-12-2027 JUNE 11, 1920 ATLANTA, GA Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas XX No MONTGOMERY POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11605 KAREN DRIVE 20854 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1XXYas 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married XIX Married 1 ☐ Yas 2√ No Specify: Specify. WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) 4 ADVERTISING MARKETING/ADVERTISEMENT 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) ABRAHAM LEEDS HANNAH SMITH 19b. Mailing Address (Street end Number or Rure! Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11605 KAREN DRIVE, POTOMAC, MD 20854 DORIS LEEDS WIFE 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) Date 20c. Location - City or Town, Stata XX Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 02-25-99 OLNEY, MD 21. Signature of Funeral Septics Ligarises DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Intarval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARTION IMMEDIATE Due to (or as a consequence of): , ARTERIOSCLEROTIC HEART DISEASE 10 YEARS Due to (or es a consequença of): Due to (or as a consequenca of)

Physician /Medical Examiner

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item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinat must be notified at

permit. Peges 1 and 2 should be filled within 72 hours effer of Department of Health and Mantal Hygiene. Important: If teem 27 is marked other than "natural", or iten any injury or other traumatic aware.

Baltimore, Maryland 21215-0020

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Examiner physicien end the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Physician/Medical that initiated events resulting in death) Last 88 USB

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETIS MELITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1□ Yas XX No 1 inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27 Magner of Death 28e. Date of injury (Month, Day Year) 28c. tnjury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and cartifier 29d. Date signed (Month, Day, Year) 29c. Licansa number

State Registrar

31. Date filed (Month, Day, Year)

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GARY FISHER, MD

1999

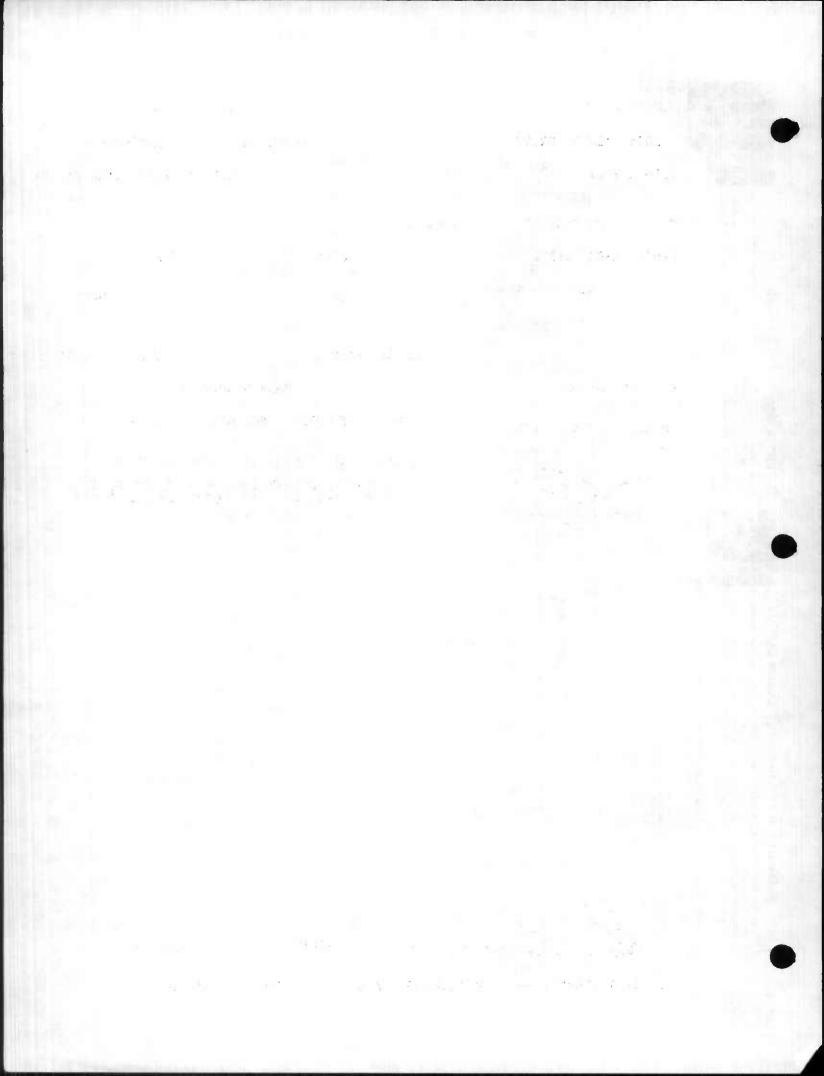
5530 WISCONSIN AVE, # 730, CHEVY CHASE, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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FEB. 24. 1999

DHMH 16 Rev 6/95

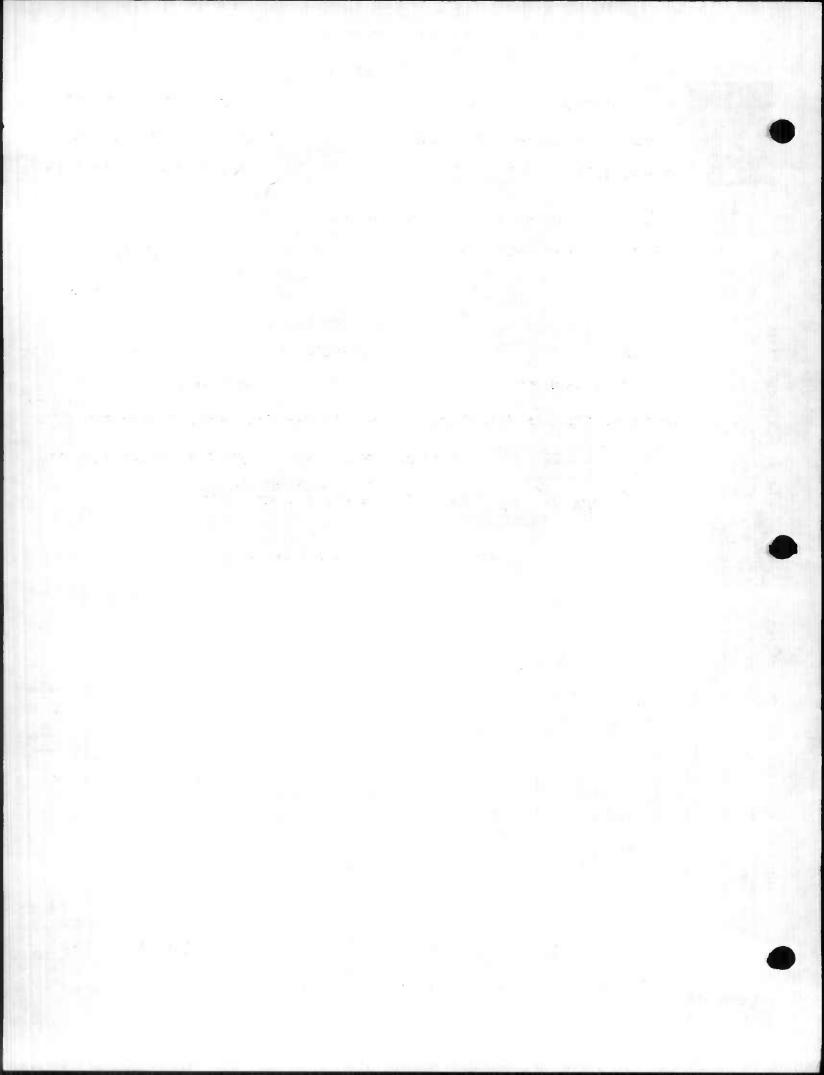


State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death **Physician** FEB. 22, 1999 1630 KATHLEEN LINCOLN /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** MONTGOMERY Olney Montgomery General Hospital If Under 24 Hrs. If Under 1 Year 8. Data of Birth Month Day, Year May 18, 1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stete or Foraign **Funeral** 1□ M 20 F Months Days Hours Min Virginia 73 Yrs. 216-38-5911 **Director** Usual Residence of Decedent with the Meryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD Montgomery Germantown Directo 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? permit. Pagas 1 and 2 should be filed within 72 hours aftar death with I Department of Haelih and Mentel Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 3 any injury or other traumetic event, the Modical Examiner mant be in once. 12305 Silver Gate Way 20874 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2XNo Specify: Black p 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6th Domestic Home 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fathar's Nama (First, Middla, Last) Henry A. Jackson Mary Redmon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 19a. Informant's Name/Relationship (Type, Print) Debra M. Lincoln (Daughter) 12305 Silver Gate Way, Germantown, MD 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from Stata Parklawn Mem. Park 2/26/99 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signard Funeral Service Licens Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart full response to the cause on each line. Approximete Intarval Batwaen Onset and Death Physician Immediate Cause (Finel disease or condition resulting In death) /Medical ntraciqual day haeyonahge Examiner Due to (or es a consequence of): Examiner attanding physician and for use as the buriel-transit requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): ed by tha a 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were autopsy findings available prior to completion of ceusa of death? 24e. Was en autopsy performed? Completed page 2 s hes 1 Yes 2 No 1 ☐ Yes 2 No cartificate or Attending Physician: funaral director, Be 25. Was cese referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Aftar this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28b. Time of 5 Pending Investigation 1 Naturel s after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, straet, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital 24 hours tsaccentifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edicai complately (Check only within 2 To the the th 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian 0 Feb 23, 1999 M 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Mendhiratta 18111 Prince Philip Dr Olney MD 20832 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

State Registrar

FEB 26 1999



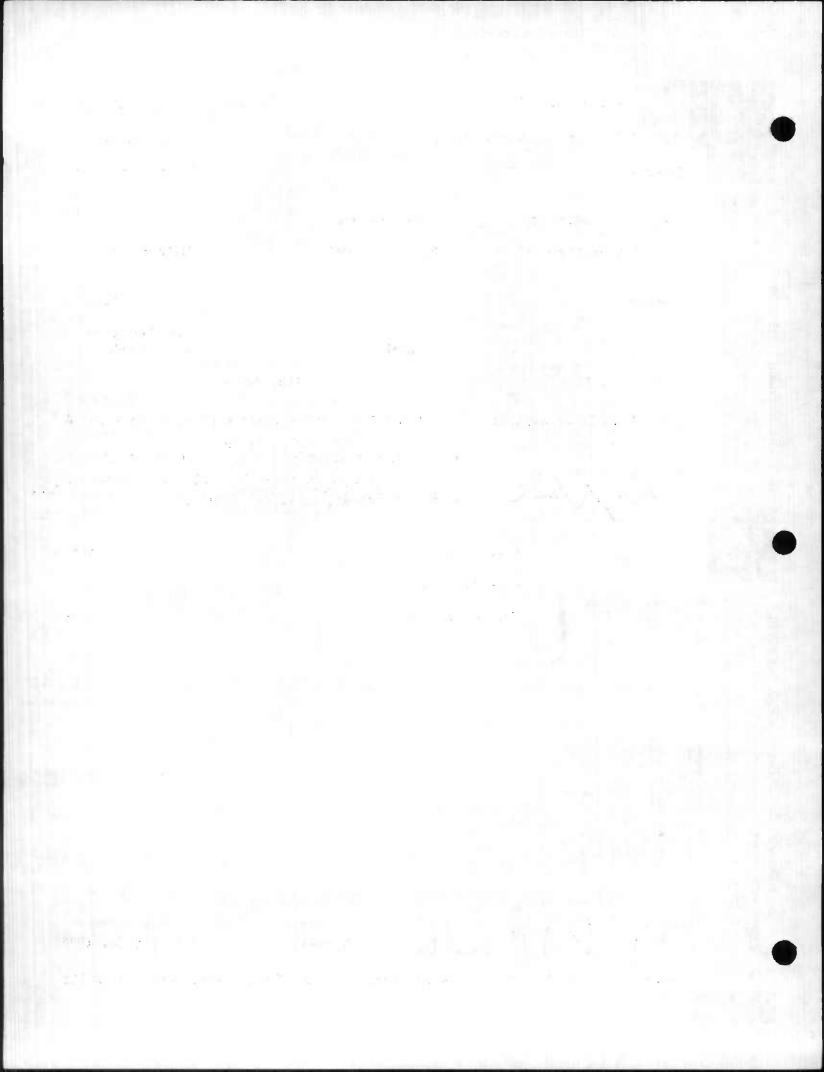
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l	20e. Method of Disp		3 □Removel fro	m State	Ob. Place of Disp cametery, cre	position (Neme of emetory or other pla	ace)Feb. 26	, 1999	20c. Location	- City or T	own, Stete
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21. Signature Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501											
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State Registrar

31. Date filed (Month, Dey, Year)
FEB 2 6 1999

32. Registrer's Signeture

G. Spark



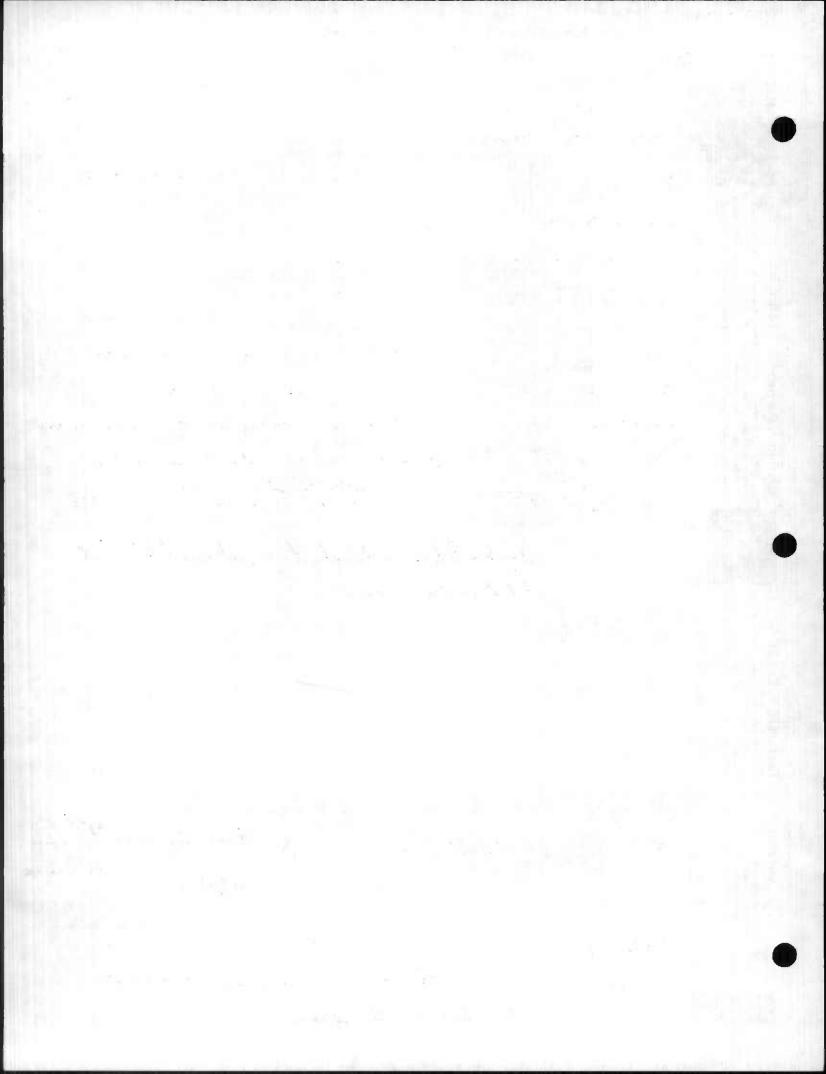
State of Maryland / Department of Health and Mental Hygiene Q 0 7251

EMMA LO	U Li			iviaryiano		tificate of			Reg. No.	0/251	
Physi	ician	1. Decedent's Name (First, Middle, Last)						Month			
	dical	Emma Lou Lewis 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or I									
Exam	niner	EASTON MEMORIAL HOSPITAL E.R. EASTON							TALBOT		
Funoral		5. Social Security Number 6. S	last birthday) If Under 1 Year		If Under 24 Hrs.	Hrs. 8. Date of Bir		Birthplece (State or Foreig Country)			
72 hours effer deeth with the Meryland naturel; or Nems 28e or 28e-f show parent control at the control of the			□ M 200XF 94 Yrs			Months Days	Hours I	Min. (Month, Da July 4		Maryland	
		Usual Residence of Decedent						15 (12)	, and the second		
		10e. State 10b. County 10c. City, Town or Location								10d. inside City Limits	
	cto	Maryland Caroline Ridgely								1 ☐ Yes 2X No	
ith th	eth with the Merylan 123a or 23a-4 show 121 or 23a-6 121 Director	10e. Street and Number 10f. Zip Code							10g. Citizen of V	What Country?	
23a		23993 Holsinger							USA		
ours efter deet	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No 1f Yes, Give Year or Dates:			S. 13. Was Decedent of Hispenic Origin? (St If Yes, specify Cuban, Mexican, Puerlo			? (Specify Yes or No Puerto Rican, etc.)	acity Yes or No- Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. Specify: Black		
72 hours	2		3 ☑ Widowed 4 □ Divorcad Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation						16b. Kind of Br	b. Kind of Business/Industry	
in 7	Be Completed	(Specify only highest gra	de completed)	45-)	(Give	kind of work done OO NOT use retire	during most of	working			
If it is a second of the control of	E	Elementery/Secondery (0-12) 5th	College (1-	-40r 5+)	Rea1	Estate	Consul	tant	Real E	state	
	9	17. Fether's Name (First, Middle, Last)						Name (First, Middle	, Maiden Suman	ne)	
of 2 should be file the and Mental Hy	To	Ernest Armstrong	, Jr.				Julia	a A. Wilke	erson		
2 sho and h		19a. Informant's Name/Relationship (Type, Print)		19b. Mallir	g Address (Stree		or Rurel Route Numb		State, Zip Code)	
CENL		Adara Macklin, N	iece		2028	So. Bee	chwood	Street, I	hiladep	hia, Pa. 19945	
of He litem		20a. Method of Disposition Burial 2 Cremation 3	Domestal from C	20	ace of Dispo	sition (Name of natory or other pla		Date	20c. Location -	City or Town, State	
nit. Pages artmant of ortant: If its Injury or o		4 Donation 5 Other (Specify			ring G	rove Cem	netery	2/27/99	Denton	, Md.	
permit. Pages 1 ar Department of Hea Important: If Itam:	9	21. Signature of Funeral September 135	Tee	22. Name and Address of Facility Bennie Smith Fun							
2052	8							, Easton,		d 21601	
physician and physician and the bunal-transit and call Examiner	resulting in death) Sequentielly list conditions, if eny, leading to immediate couse. Enter Underlying Ceuse (Disease or Injury that Initiated events	p. Card		as a consequence as a consequence	uenca of):	8	the pertand				
daath certificate be ex e attending physician of for use as the buna	a a	resulting in death) Last Due to (or as e consequence of): d.									
death death death	Cia	Pert II. Other significant conditions of	ontributina to de	ath but not resul	Iting In the u	nderiving cause gi	iven in Part i.	23b. Did	23b. Did tobacco use contribute to the cause of death		
hat the od by th	by Physician/M						10	1 Yes 2 No 3 Probably 4 Onknow			
v requii	Completed								an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?	
delan: The la cartificate ha	EOC							18	2□ No	1 Yes 2□ No	
ysician: The lav is cartificate has director, page 2	Be	25. Was case referred to medical examiner?					26. Place of	Death (Check only	one)		
Physician: rthis cartific rral director,	2	XX Yes 2 No		ing Home 5□ Res	denca 6 □Oth	ner (Specify)					
ttending deeth. ctor: After y the fune	Certification:	27. Manner of Death Natural 1 Natural 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 which Sins 28d. Describe how injury occurred 5									
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only one) (Check only one) (Check only one)		sis of exeminetic		estigation, in my	opinion, death	blaca, and due to the occurred at the time,	dale end place,	end due to the cause(s)	
To To	2	29b. Signature and title of certifier 29c. License number O.C.M.E							FEB. 23, 1999		
	State	30. Name and address of person who all the post of the same and address of person who all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person who are all the same and address of person are all the same are all the same and address of person are all the same are all the sa	completed cause		lll Pe		t, Balt	imore, Ma	ryland :	21201	

pressure B. Sparks

FEB 2 5 1999 >

State Registrar



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Physician Month Sarah Collins Hadaway Lane February 21, 1999 11:00AM /Medical 4a. Facility Name (If not institution, give street and number) Kent and Queen Annes Hospital 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Chestertown Kent if Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)
June 19,1906 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. lest birthday) 5. Sociel Security Numb 221-14-6338 **Funeral** Deys Hours 1□ M 2X F Yrs 92 Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, in Medical Examiner must be notified at Maryland Kent 1X Yas 2 □ No Chestertown Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1 201 Radcliffe Drive 21620 USA Funeral 2 should be filed within 72 hours after deeth n end Mental Hygiena. Is marked other than "natural", or items 23. 14. Race - American Indien, Black, Whita, atc. 12. Wes Dacedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritet Status 1 Naver Married 2 Married 1 ☐ Yes 2√ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be James Thomas Hadaway Gertrudee Hannah Carter 2 permit. Pages 1 end 2 sh Depertment of Haalth end Important: If Itam 27 is m any injury or other traum 19a. Informent's Neme/Retationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Crowding Yerkes/Daughter 25711 Pearce Way, Chestertown, MD 21620 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Buriet 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Chester Cemetery 2/18/99 Chestertown, MD 21. Signatura of Funerat Service License 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cerdiac or respiretory errest shock, or heart failure. List only one cause on each line. Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner onemmon? buriel-transit Sequentielly list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest pue physician s the buriel Box 68760. 8 Physician/Medical 80 attending 950 Po Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 □ Yes 2 □ No 3 □ Probably À 24b. Were eutopsy findings avaitable prior to completion of ceusa of deeth? 24a. Was en eutopsy performed? Completed peed pega 2 s has 1 Yes 20 No 1 ☐ Yes No certificate Division of Vital Hospital or Attanding Physician: 24 hours aftar death. Funeral Director: Aftar this certifici Be 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Datatient 0 1 Yes 2 No 2 ER/Outpetient 3 DOA funeral 27. Manner of Deeth Certification: 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of exeminetion end/or invastigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a, Certifier Medical 29b. Signature end title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 6 30. Nama and eddress of person who compaged ceuse of deeth (Item 23e) (Type, Print) Fredrick Delboy, MD 6602 Church Hill Road, Suite 200, Chestertown, Maryland 21620 31. Dete filed (Month, Day, Year)

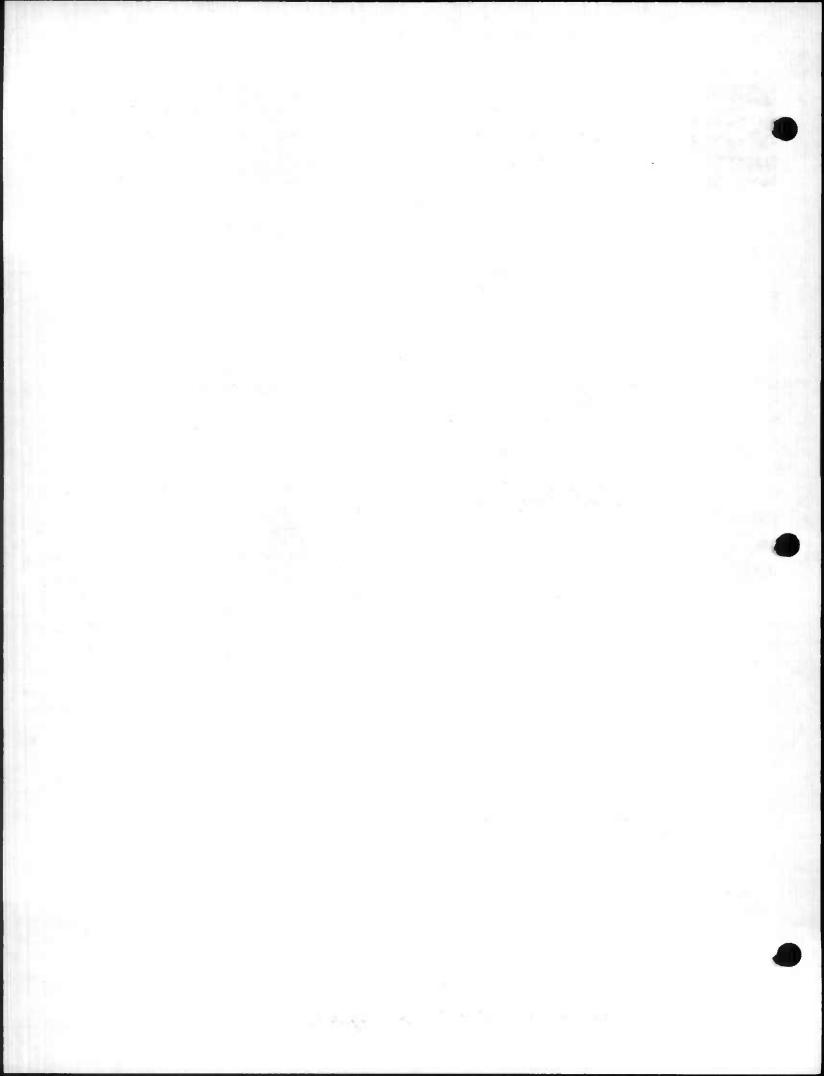
32. Registrar's Signature

FEB 2 6 1999

DHMH 16 Rev 6/95

State

Registrar



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 24, 1999 **Physician** 4:30 A.M. Edward William Lempke, Jr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) SEPT. 2, 1920 WASHINGTON, DC 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Hours 577-24-0455 Director Usual Residence of Deceden the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No ST. CHARLES MD CHARLES Director 28a-f 10e Street and Number 10f. Zin Code 10c. Citizen of What Country? 8 UNITED STATES 20602 Norma 23a 122 STODDERT AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1) Yes 2 No ARMY
If Yes, Give
Year or Dates: 1943-46 1 Never Married 2 Married WHITE altimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Spacify à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiere. Importants if item 27 is marked other than "say in lury or other traumatic event, the lates. Elementary/Secondary (0-12) College (1-4or 5+) WILSON MEAT CO. 12 SALESPERSON 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 88 EDWARD WILLIAM LEMPKE, SR. UNKNOWN 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) LUTHER P. McCOY, JR. / EXECUTOR 12405 CHALFORD LANE BOWIE, MARYLAND 20715 20a. Mathod of Disposition
11 Burial 2 ☐ Cremation 3 ☐ Removat from 20b. Place of Disposition (Nama of cemetary, crematory or other place CHELTENHAM ate 20c. Location - City or Town, State AND VETERANS' CEM. 3/2/1999 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerat Service License 22. Name and Address of Facility HUNTT FUNERAL HOME, INC. DAVID A. GOFF 3035 OLD WASHINGTON ROAD WALDORF, MARYLAND 20604 M01095 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** careful viscula Accident /Medical Immediate Cause (Finat Sweeks disease or condition resulting in death) Examiner Due to (or as a consequence of): Swelts Examine Pheuninia physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 90 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yaa 2 No 3 Probably 4 Unknown ATRAIL CISCOLATION Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospitat: ↑ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of Certification: 28c. tnjury at Work? After 1 Natural 5 Pending To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

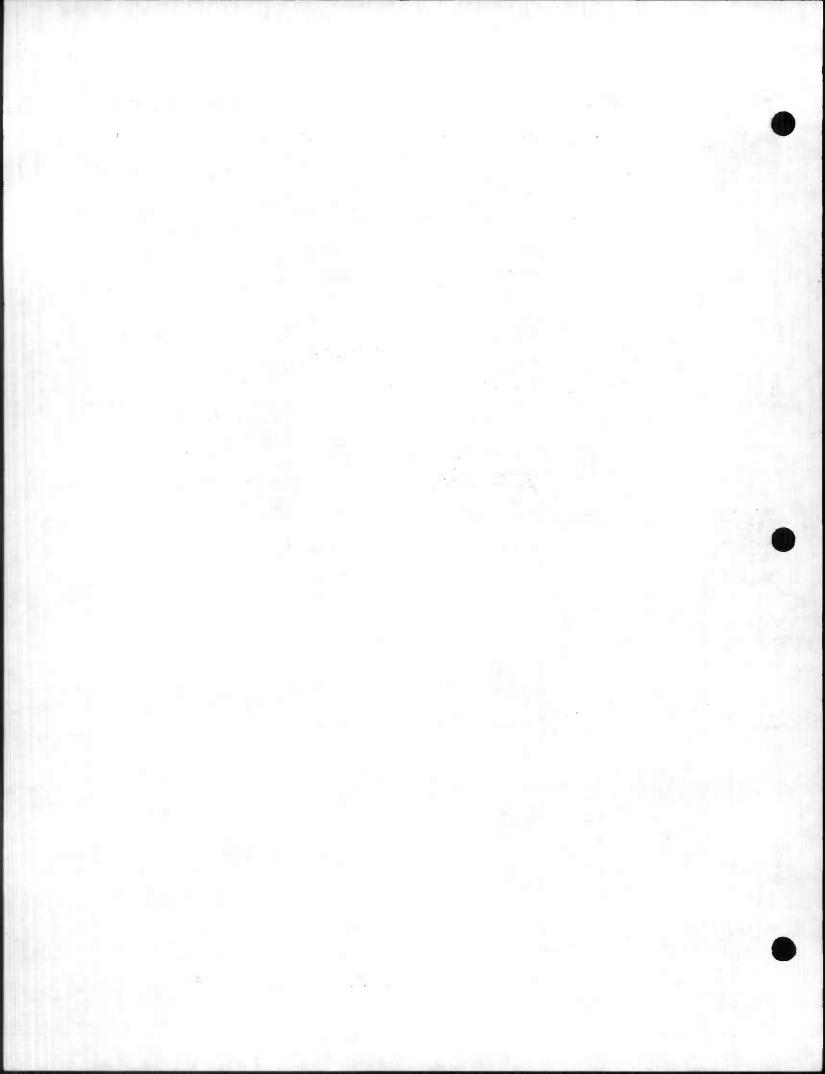
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number) Jame FS. 24, 1999 035206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Lucyston RA Frwst. uns 20746 William T. Tonnerm 31. Date filed (Month, Day, Year)

Registrar

DHMH 16 Rev 6/95

32. Registrar's Signature

FEB 26



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Yaeı LEOLA BOWMAN LONGERBEAM **FEBRUARY 24 1999** 7:55AM 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth SACRED HEART HOSPITAL CUMBERLAND ALLEGANY if Under 1 Year if Under 24 Hrs. Birthpiaca (Stele or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yaer) Months Days Hours 1 M 2 F Yrs. 23,1920 PENNSYLVANIA 78 214-07-2443 AUG Usual Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No MARYLAND ALLEGANY CRESAPTOWN 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Coda 12828 DARROWS LANE 21502 USA 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Maritai Status Black, Whita, etc. 1 ☐ Yas 2 █No If Yes, Give Yeer or Dates: 1 □ Naver Married 2 □ Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Flementary/Secondary (0-12) TEXTILE TWISTER FIBER 9 18. Mothar's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) MILLER BOWMAN MAY HOLLER BOWMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARRELL BOWMAN/SON 12828 DARROWS LANE, CRESAPTOWN, MD 21502 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition FEB 1 Burial 2 □ Cramation 3 □ Ramoval from State SALISBURY CEMETERY 25,1999 SALISBURY, PA 4 ☐ Donation 5 ☐ Other (Specify) Management Servica License 22. Name end Address of Fecility HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiec or respiratory arrast, shock, or haart failure. List only one ceuse on each line. Approximata Interval Between Onset end Daath Immediate Ceuse (Final disaasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disaasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part fl. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 25 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death?

Physician /Medical Examiner

Physician

· /Medical

Examiner

10a State

Directo

Funeral

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Completed

Be

2

Funeral

Director

with the Marylend

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health end Mental Hygiene. Important: If Item 27 is merked other then "natural", or Items 23s or 28s-1 show any injury or other traumetic event, the Medical Examines must be notified as

altimore, Maryland 21215-0020

Box 68760. certificete be

P.O.

Records,

Division of Vital

Physician:

or Attending

Examiner physician end the burial-transit 88 980 ō detached page 2 Be P L

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After!

efter death.

To the Hospital within 24 hours To the Funeral (Hospital

Physician/Medical by Completed funeral director, Certification: filled in by

6. Place of Daath (Check only one)

1 Yes 2 No

Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

2 No

Location (Streat end Number or Rurel Route Number, City or Town, Stete)

29a, Certifie (Check only one)

Hospital:

5 Pending investigation

8 Could not be datermined

Inpatient

28a. Date of Injury (Month, Dey Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceusa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. Licansa numba

umberland

29b. Signature and titla of certifier

30. Nama and addrass of person who completed cause of death (Item 23a) (Typa, Print)

soad

28c. fnjury at Work?

1 Yes

FEBRUARY 25 1999

This

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Medicai

State Registrar

lelipa 31. Dete filed (Month, Day, Yeer) 25

monne

25. Was casa referred to medical examinar?

1 Yes 2 No

27. Mannar of Death

1 Natural 2 Accident

3 Suicide

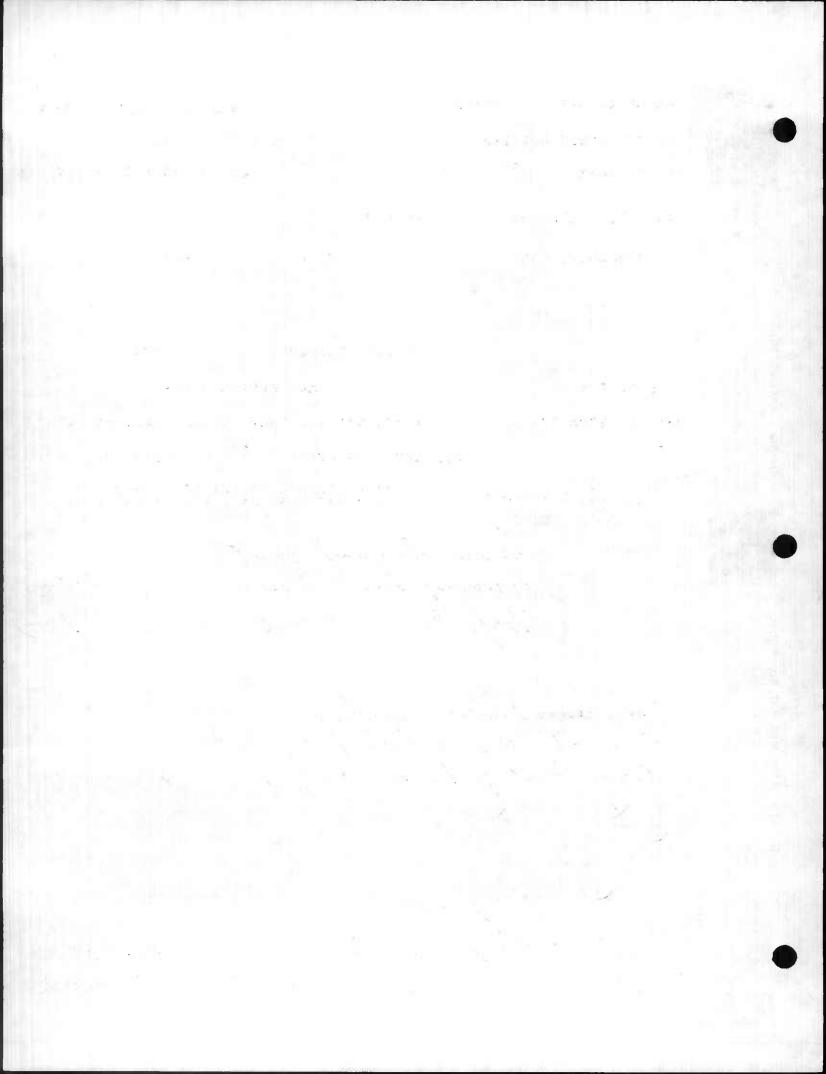
4 Homlcide

5 Bishop Walsh 2 32. Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Tima of

28e. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify)

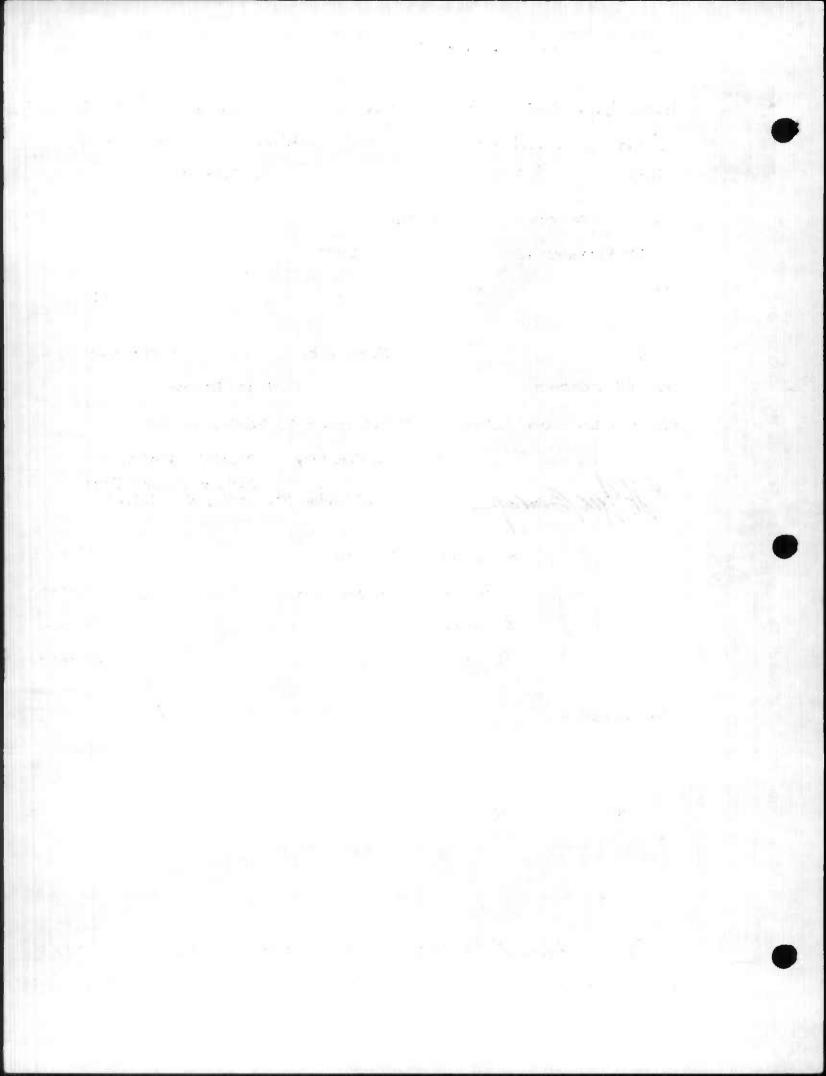


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Ebruary 15,19 Boy Michael Roscoe Lederman Baby /Medical 4b. City, Town, or Location of Death 4c/County of Death 4a Facility Name (If not institution, give street and number) Examiner Hopkin 5 HOS Baltimore City orta **Baltimore** ohns | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | 42 | 2 / 15 / 99 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 10XM 20 F MD Director None Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiena. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinal trust be not?" and anote. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No MD Worcester Berlin Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 100 Pinehurst RD 21811 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amaricen Indian. 11. Marital Status Black, White, etc. Never Marriad 2 Married 1 Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) None/ Baby None/ Baby 0 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middla, Last) Russell Lederman Christine Roscoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Christine Lederman/ Mother 100 Pinehurst RD Berlin, MD 21811 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Ramoval from State 2/19/99 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 22. Name and Address of Facility Sarvice Licensee Burbage Funeral Home 108 William St. Berlin, MD Approximata Interval Between Onset and Death complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, any one cades on each line. Physician /Medical Immediate Cause (Final diseasa or condition rasulting in death) 42 minutes Respiratory tailure Examiner Examiner Bilateral lung hypoplasia 12 weeks physician and the burial-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaase or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Anhydramnios 18 weeks Physician/Medical Due to (or as a consequence of) 88 Polycystic Kidneys 20 weeks signed by the a Part II. Other significant conditions contributing to death but not rasulting in the undarlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Hydrocephalus Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy is certificate has director, page 2 1 Yas 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Invastigation After 1 Natural 1 Yes 2 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu death. 2 Accidant 6 Could not be 3 Suicida Location (Street and Number or Rurel Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Data signed (Month, Dey, Year) 29b. Signatura and title of certifier 29c. Licanse number RES-000 February 15, 1999 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) Christopher Golden MD 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar 31. Date filed (Mooth Day, Yeer) FEB 23

32. Begistrar's Signature



altimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day -Physician Ruth Esther MAIN February 22, 1999 7:42 a.m. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Clearview Nursing Home Washington Hagerstown If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5 Social Security Number 228-2**6**-2903 If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) Funeral Months Deys 1 □ M 2 K F Yrs. 86 Oct. 26, 1912 Maryland Director Usual Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Menylan is Health and Mental hygiens.

The file of the file of 1X Yes 2 No Maryland Washington Hagerstown Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 617 Chestnut Street 21740 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Meritel Status Bleck, White, etc. 1 Yes 2X No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: by white 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) dental assistant dental office 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be George Elmer Brengle Virginia Schley 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sh Department of Health end Important: If itsm 27 is m any Injury or other traum once. 17960 Garden Lane, Hagerstown, Md. 21740 Michael Main - son 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 🖾 Cremetion 3 ☐ Removel from State 2-23-99 4 Donetion 5 Other (Specify) Hagerstown, Maryland Hagerstown Crematory ame end Address of Fecility MINNICH FUNERAL HOME 21. Signeture of Funerel Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 21740 ar 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Physician Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical e Cardiopulmonary Arrest Instant **Examiner** Due to (or es e consequence of): Examiner Congestive Heart Failure 1 week attending physician end for use as the burial-trensit deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Hypertension, Arteriosclerotic Heart Disease many yrs Physician/Medicai Due to (or es a consequenca of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease by 24b. Were eutopsy findings aveilable prior to Completed 24e. Wes en eutopsy performed? Diabetes Mellitius non insulin requiring completion of cause of deeth? page 2 s hes Anemia due to intestinal bleeding 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificete or Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: A Nursing Home 5 Residence 6 Other (Specify) To this funeral 28d. Describe how injury occurred 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: After 1 Naturel 5 Pending efter deeth. 1 TYes 2 □ No 2 Accident the 6 Could not be determined 3 Sulcide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homlcide filled in Hospital 24 hours 29e. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated. edical completely 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner stated. (Check only one) To the within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 2-23-99

State Registrar

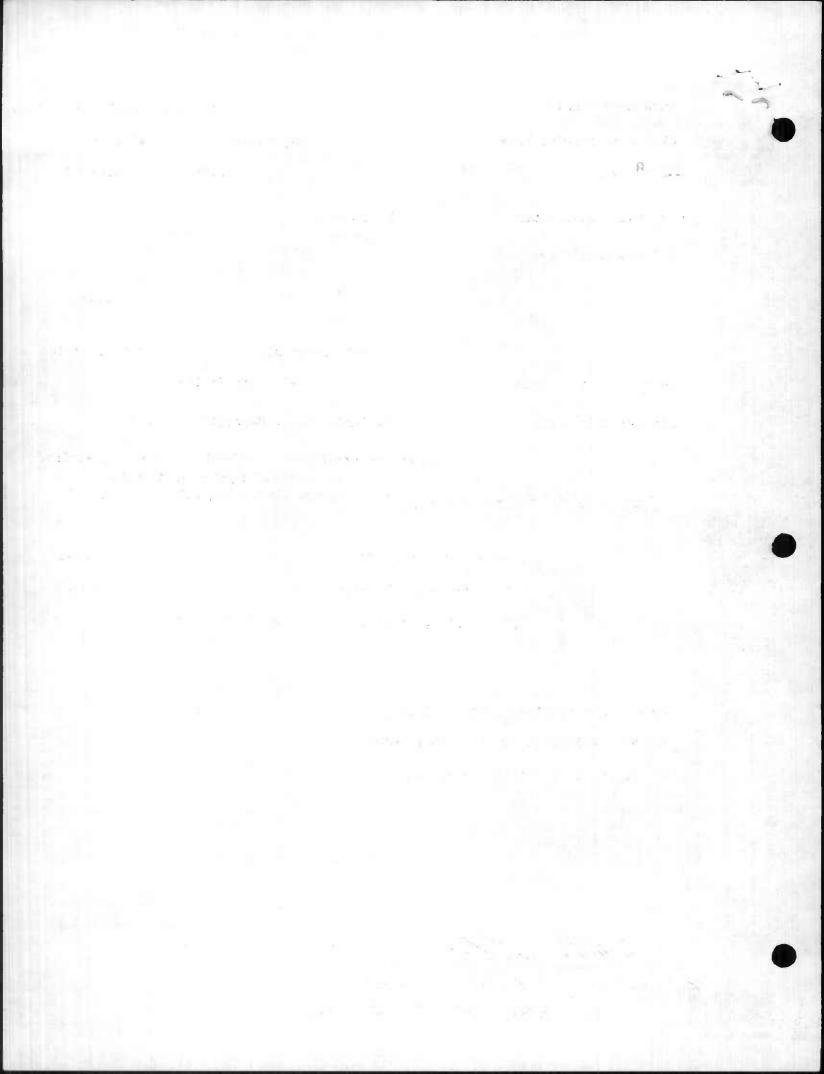
. E. B. Moody, 1190 Mt. Aetna Rd. Hagerstown, MD 21740 31. Dete filed (Month, Dey, Year) 32. Registreds Signature

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

3 1999 ▶ FEB 2

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State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 955 AM Ruth Gladys MULLIGAN -eb. 22 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) March 12,1914 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Deys 1 M 2 SF Yrs. 214-36-0082 84 Director West Virginia Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Maryland Washington Hagerstown 288-1 10f. Zip Code 10e. Sfreef and Number 10g. Citizen of What Country? 23a or 440 George Street 21740 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Rece - American Indien, 11. Meritel Status Black, White, etc. filed within 72 hours after Yes 2 No 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: by white 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 0 homemaker her own home 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Charles Holton Dosha Caldwell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) of of Health a tiff them 27 is or other tra Patsy Dennis - daughter 922 Corbett Street, Hagerstown, Md. 21740 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory 2/23/99 Hagerstown, Maryland Name and Address of Fecility MINNICH FUNERAL HOME 21. Signeture of Frmerel Service Licenses \$15 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on aech line. **Approximate** Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel diseasa or condition resulting in deeth) /Medical Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of) Physician/Medical Dua to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 → Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? Lycentia 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital Be 25. Was case referred to medical axeminer? 26. Place of Deeth (Check only one) Hospitel: Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ö 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Maturel 2 Accident 1 ☐ Yas 2 ☐ No after deatl 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours • Funeral 1 Certifying Physician: To the best of my knowledge, death occurred et the time, data end plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. Medical 29a. Certifier (Check only in in ä 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 30. Neme and address of person who completed cause of death (item 23e) (Type, Print) Cood mt 1190 Hetna Mlood

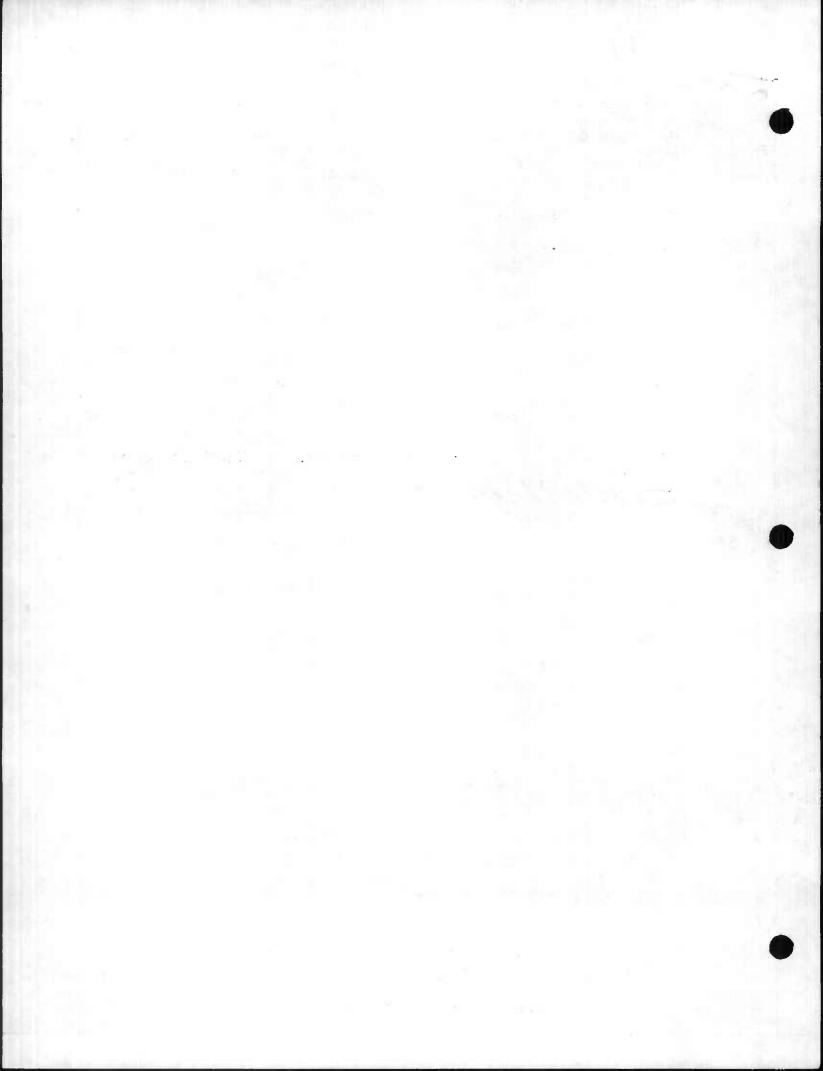
Registrar

State

31. Dete filed (Month, Dey, Year)

FEB 2 4 1999

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Alice Mae METZ february 20, 1999 4b. City, Town, or Location of Death /4c. County of Death 4a Fscility Name (If not Institution, give street and number) Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Dey, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) Months Days 1□M 2⊠F Hours 146-18-5722 Yrs. 77 Jan. 18, 1922 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 142 Buttercup Drive 21740 USA 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2K Married 1 ☐ Yes 2 ☑ No Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nurse hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) William Garfield Groshon Nellie Creager t 9a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer P. Metz, Sr. - husband 142 Buttercup Dr., Hagerstown, Md. 21740 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harbaugh's Cemetery Feb. 24, 1999 Rouzerville, Pa. 4 ☐ Donation 5 ☐ Other (Specify)

py

Completed

Be

Medical Certification: To

page 2

carlificata

24 hours after deat Funeral Director:

within 2 \$

or Attending Physician:

Physician

/Medical

Examiner

10a. State

12

21. Signeture of Euneral Service Licenses

Funeral

Director

Framiner must be notified at

"natural", or

hours after

altimore, Maryland 21215-0020

Director

Funeral

à

Completed

Be

Physician /Medical Examiner

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked or any Injury or other traumatic eve

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Physician/Medical

Immediate Cause (Final disease or condition resulting in death)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. maravagalow coaquiatro

turon besses Due to (or as e consequence of)

22. Name and Address of Facility

Candroa Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

immel

unknown etolog

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed?

Approximete Interval Between Onset and Deeth

aye

1 Yes 2 No 26. Place of Death (Check only one)

25. Was cese referred to medical exeminer? 1 ☐ Yes 2 No 27. Menner of Death 1 Natural 2 Accident

28e. Date of Injury (Month, Dev Year) 5 Pending investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

MID

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

29e. Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

29c. License number

VERRY

ino

29d. Date signed (Month, Dey, Year)

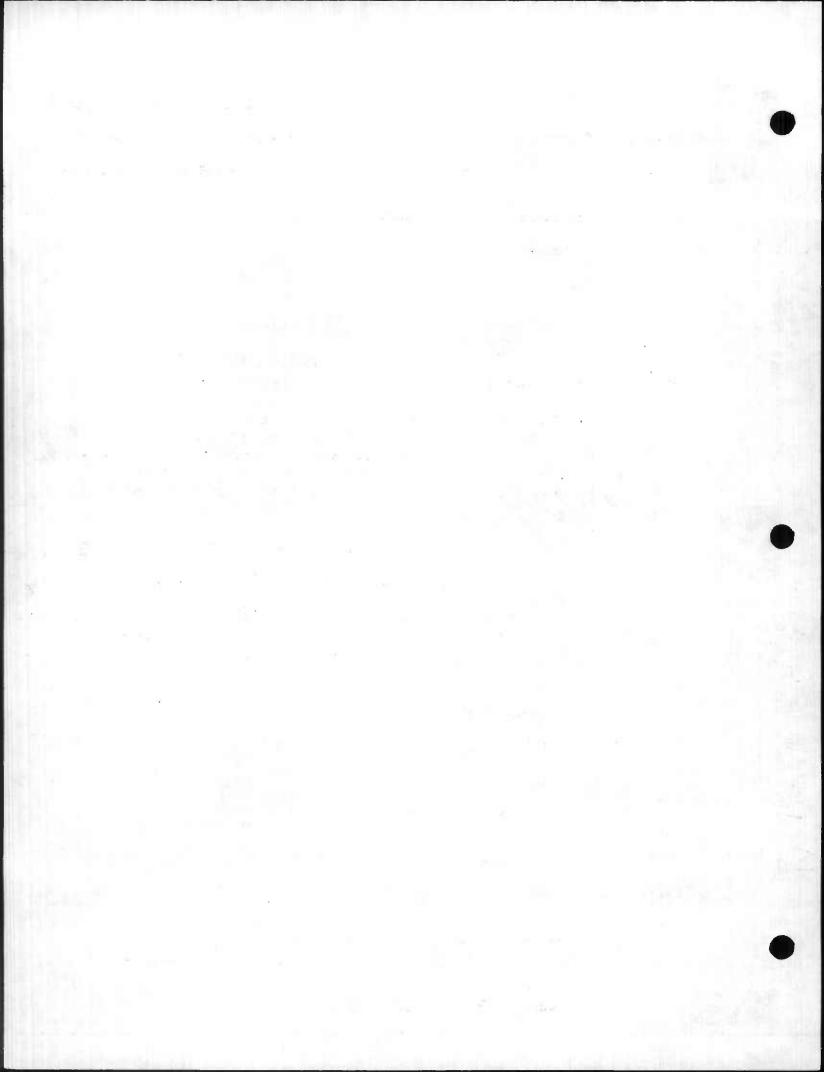
State

31. Date filed (Month, Dey, Year) EB

Registrar

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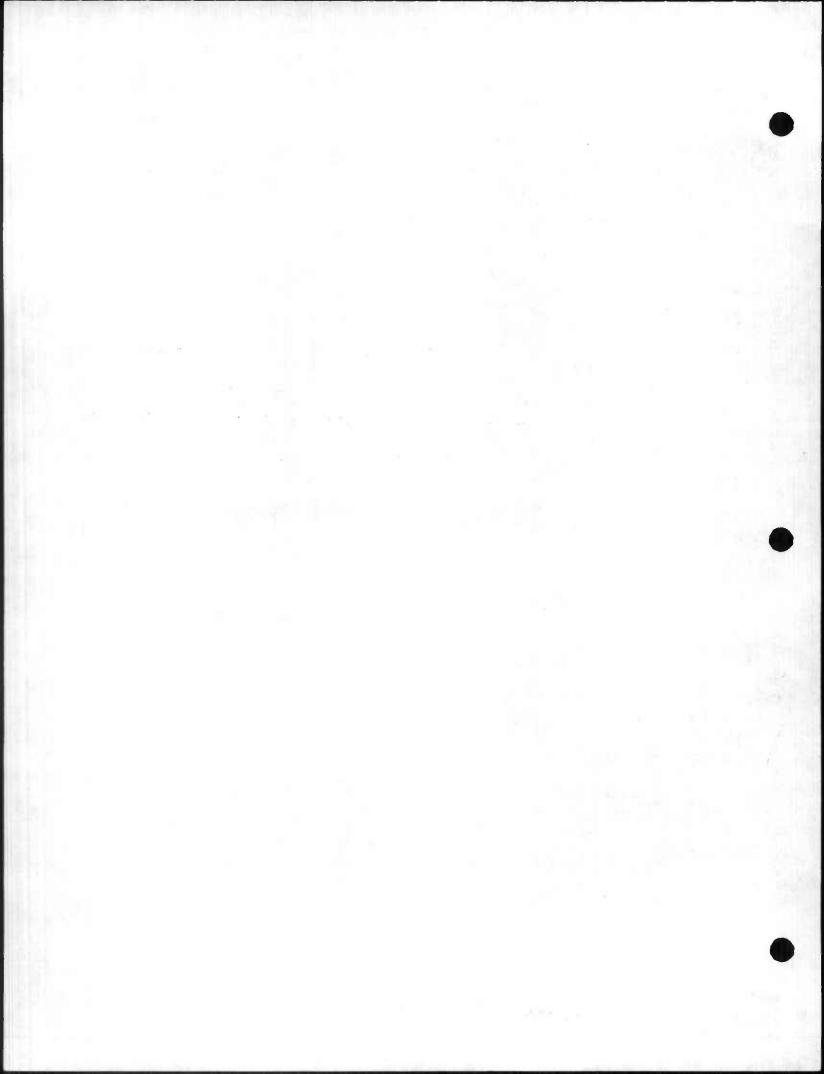


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Ruth Hering Middlekauff 19 February 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) June 19,1920 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2□ F Yrs 213-18-9270 Director 78 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No Directo Maryland Washington Co. Hagerstown "naturel", or hems 23a or 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 13324 Clopper Road 21742 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 K No Specify: Specify: White ğ 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy.
Important if New 27 is marked offer, any Injury or other X-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Hering Vada Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh E. Middlekauff/ Son 1036 Woodland Way Hagerstown, Maryland 21742 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Smithsburg Crematory 2-20-1999 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalum of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 234 Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate Interval Between Interval Between Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat diseese or condition resulting in death) /Medical Ischemic Colitis 2 weeks Examine Due to (or as a consequence of): Examiner FIBFOSIS Progressive Pulmonar months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yas 2 No Staphylococcal Sepsis 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner?

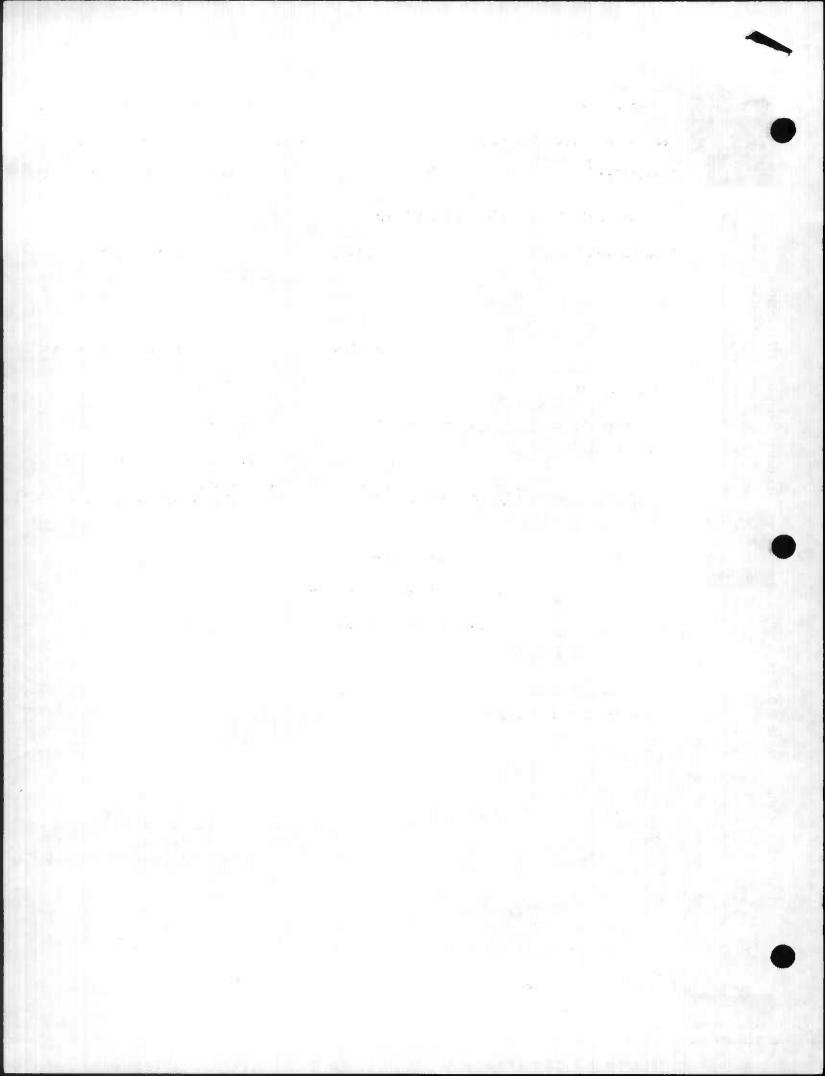
1 Yes 2 No Be 26. Place of Death (Check only one) Hospitat: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of injury (Month, Day Year) 28b. Time of Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stelled. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Centra Kuttner-Vando mo February 19, 1999 D47451 30. Name and address of parson who completed cause of death (item 23a) (Type, Print) Hagerstown, Maryland Cynthia Kuthner-Sands, mp 11110 Medical Campus Rd. Suite 130 32. Registrar's Signature 31. Date filed (Month, Day, Year) State parks FEB 2 2 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 7 2 6 0

	/99, BMW, Montg. Co 1. Decedent's Neme (First, Middle,			3 - 1			Death	2. Date of D	Reg. No.	3. T	ime of Death	
an	Lottie Marti	n						Februar	y 17, 19	999 6:	15 PM	
cal ner	4a Facility Neme (If not institution,	give street end nur	n <i>ber)</i>			4	b. City, Town, o	r Location of Dee	th 4c. County	of Death		
	Laurel Regiona	1 Hospita	al				Laurel		Princ	ce Georg	ge's	
	5. Social Security Number 231 1-28-3378	5. Sex 1 □ M 2 ሺ F	7. Age (In yrs. 7	last birthday). 6 Yrs.	If Under Months	1 Year Deys	If Under 24 Hr Hours Min		irth ay, Year) 1922	9. Birthplace (S Country) North C	State or Foreign Carolina	
	Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Loc	cation					10d Inc	side City Limits	
5	73. 73.6	George'		ital He		S					Yes 2 No	
	10e. Street and Number				10f. Zip				10g. Citizen of	What Country?	-	
	6908 Canyon Dri	ve			207	43			United	States		
	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	rces? 2A No re	as? if Yes, specify Cuban, Mexican, Puerto Rican, etc.) I □ Yes 2 □ No Specify: Sp.						14. Rece - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's	Education		16a. Deced	ent's Usua	l Occup	ation during most of w	rorkina	16b. Kind of B	usiness/industry		
Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)				1)		Federa	al Gover	nment	
										mie ii C		
1 20 E	Louis Alston	ao()						e Fuller				
	19a. Informant's Name/Relationshi	p (Type, Pnint)		19b. Meilin	g Address	(Street			ber, City or Town,	State, Zip Code))	
	Florence Richb		ighter						rlboro,			
	20a. Method of Disposition		20b. I	Place of Dispos cemetery, crem	sition (Nan	ne of		Date		- City or Town, S	tate	
	1 Surial 2 Cremation 3		State	ock Cre				2/23/99	Washir	ngton, D	.C.	
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility. MCGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory errest, shock, or heart failure. List only one cause on each line.											. 2001:
Examiner	Due to (or as a consequence of): Congestive Heart Failure Sequentielly list conditions, it any, leading to immediate cause. Enter Underlying Cause, (Disease or injury Lischemic Cardiomyopathy											
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200	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the ur	nderlying c	ause giv	en in Part I.	23b. Die	d tobacco use co	ontribute to the	cause of death?	
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Completed by									s an autopsy formed?	evailable	utopsy findings e prior to ion of cause ?	
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	25. Was case referred to medical examiner?	11						eath (Check only	one)			
	1 ☐ Yes 2 🛣 No			ER/Outpatien			4 LI Nursing		sidence 6 Ott			
Callon	27. Manner of Death 1 Natural 5 Pending 2 Accident investige 3 Suicide 6 Could no	etion	of Injury th, Day Year)	28b. Time of Injury	M	28c. Injur Wor 1 🗆	ry at rk? Yes 2 □ No	28d. Describe how Injury occurred				
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Σ	29b. Signature and title of certifier										Year)	
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29c. License number 29d. Date signed (Month, Dey, Year) 29c. License number 29c. License number 29c. License number											
	30. Name and address of person w	ha campleted core	o of doods (lac	02a) (Time	Deint							



State of Maryland / Department of Health and Mental Hygiene 9 9

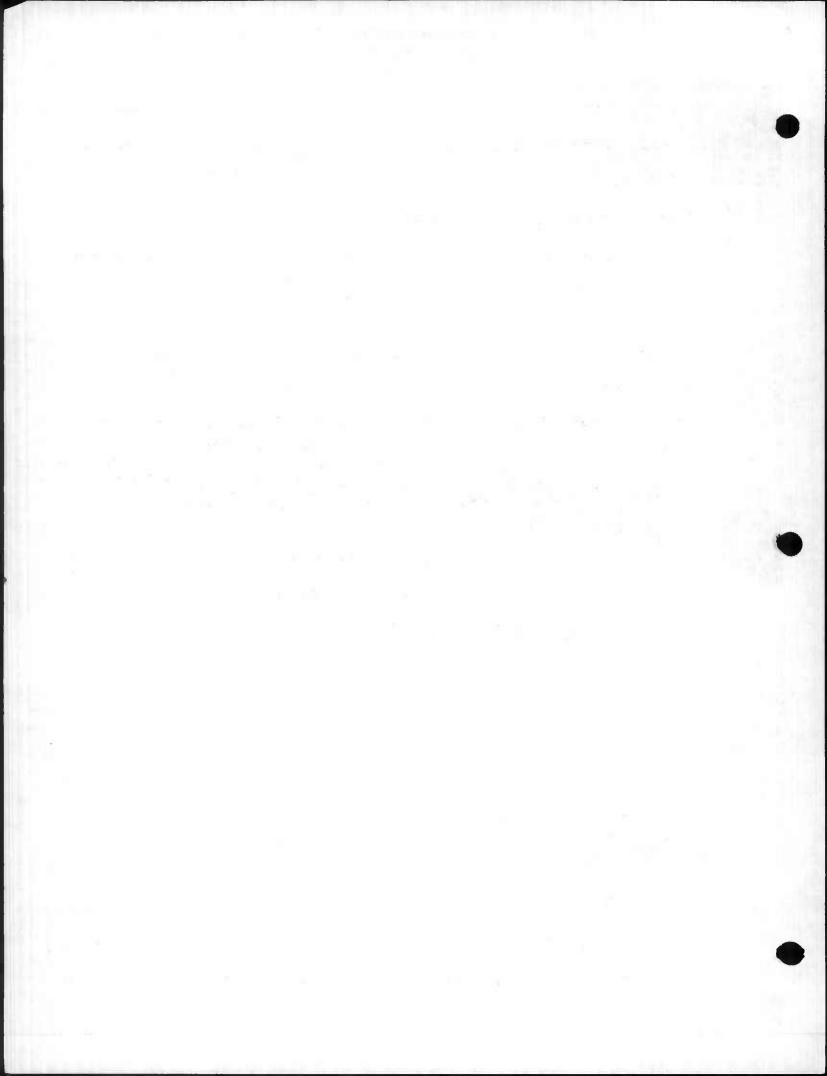
Certificate of Death

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aminer	r f	 Fecility Name (If not Institution, given 	a straat and number)				4b. City, 7	Fown, or Lo	ocation of Deat	ation of Death 4c. County of Death						
		Shady Grove A 5. Social Security Number 6. S					Roc	kvil er 24 Hrs.								
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The Land		19a. Informant's Name/Ralationship (er, City or Town						
Ē	-	Lettie A. Hough/	Niece	201 51						s, Mary						
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State Registrar

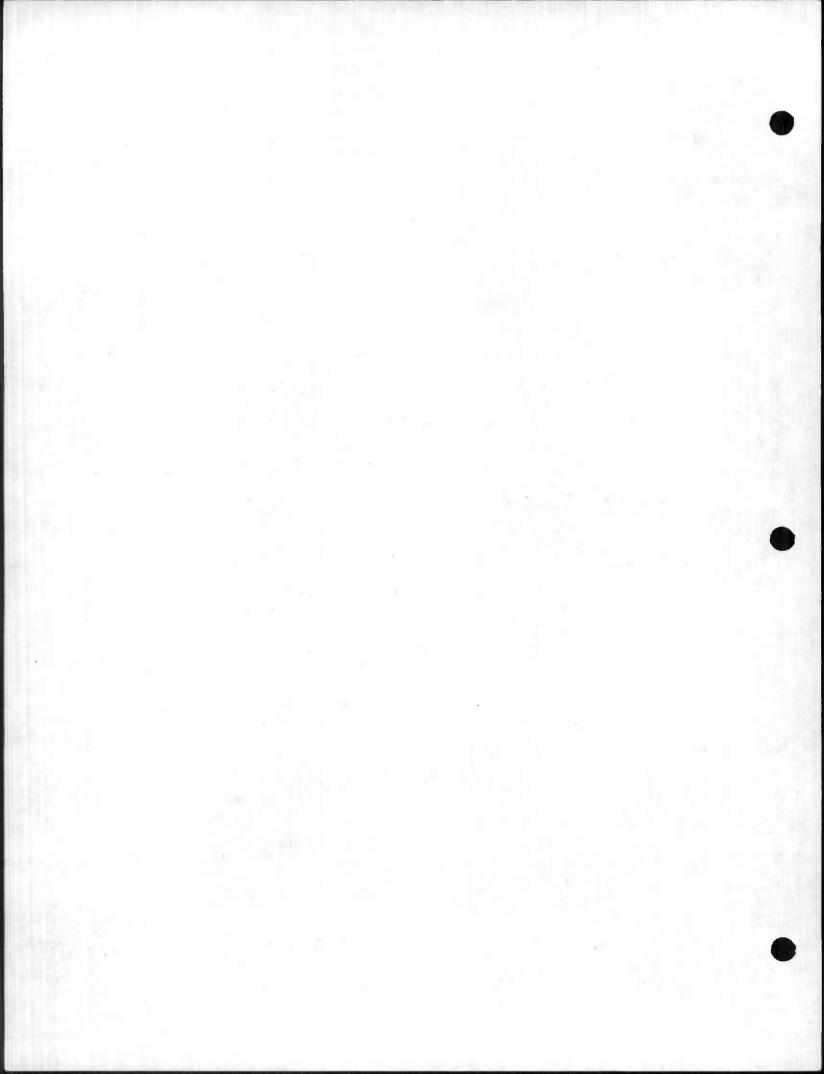
31. Date filed (Month, Day, Year) FEB 2 3 1999 32. Registrar's Signatura

G. Sporks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month **Physician** Ethel Louise McDonnell February 21, 1999 2:15 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7720 Warbler Lane Derwood Montgomery 8. Data of Birth (Month, Day, Year) Aug. 23, 1 If Under 1 Year | If Under 24 Hrs 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Hours Months 1□ M 2⊠ F 76 Yrs 577-20-8100 1922 Washington, DC Director Usual Rasidence of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yas 2 No Director Montgomery Derwood 10a Street and Number 10f Zin Code 10g. Citizen of What Country? 7720 Warbler Lane 20855 USA Funeral death 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ②No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status Black, Whita, atc filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 White "natural", or 1 Yas 2 No Specify: Specify. à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "na any injury or other traumatic avent, in Hode page. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Clayton Carrick Ruby Basye 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) William McDonnell/Husband 7720 Warbler Lane, Derwood, MD 20855 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from Stata 4 □ Donation 5 □ Othar (Specify) 2/25/99 Parklawn Memorial Park Rockville, MD 22. Nama and Address of Facility Francis J. Home, Inc. 500 University Collins Funeral Blvd., West 21. Signature of Funeral Sarvice Licansee Silver Spring, MD 20901 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Daath **Physician** /Medical tmmediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner bunial-transit The law requires that the death certificate be executed and Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or injury that initiated events rasulting in daath) Last physician the burial Box 68760. 0 Physician/Medicai Dua to (or as a consequence of) califee Reellets Ca 980 P.O. Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown veriel Cerebrousale Division of Vital Records, þ 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed Color cir/hous mo 1 Yes 2 No reato 1 ☐ Yas 2 No or Attending Physician: 25. Was casa refarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Certification: To 1 Yas 25 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 125 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital edical 29a. Cartifier 🔁 Certifying Physicien: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. Licensa number 29b. Signatura and tilla of certillo 29d. Data signed (Month, Day, Year) 7 cbrum 22,199 0 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Con theshing MD 20878 1.AD Michne 1500 57 31. Data filed (Month, Day, Year) Registrar's Signatura State Registrar FEB 25 1999



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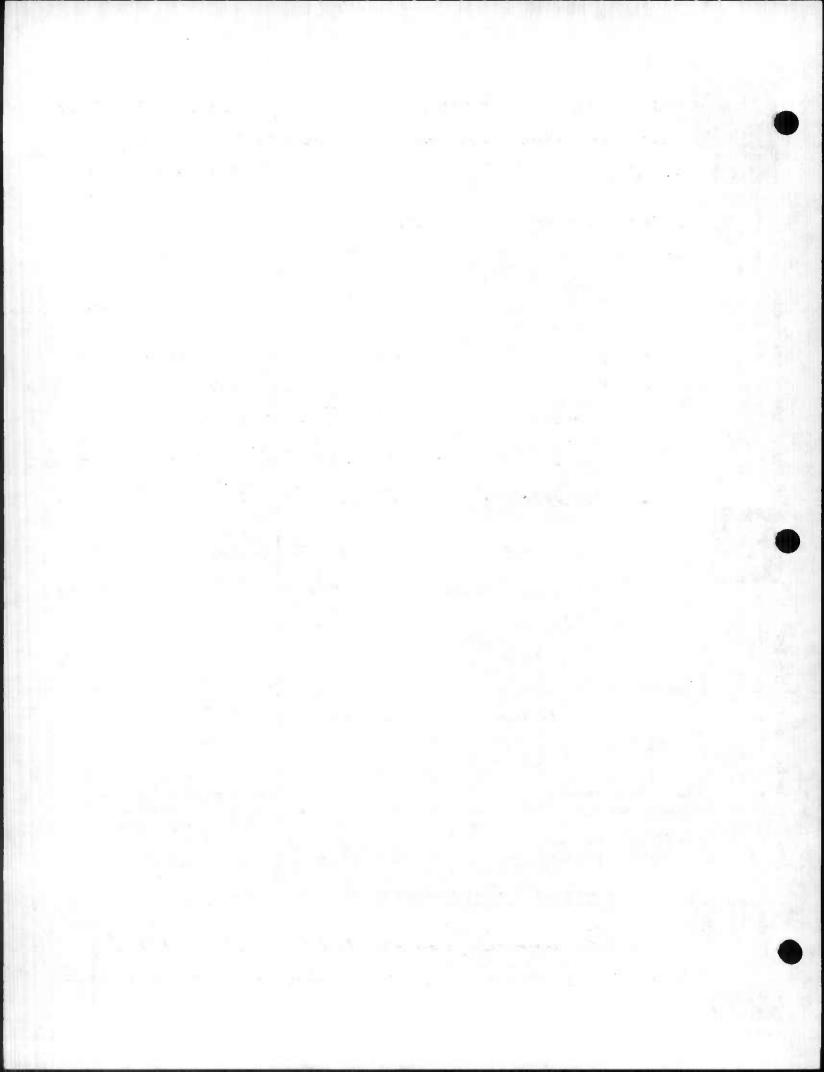
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	MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, C	HEVERLY, N	MARYLAND 2078							
State Registrar	FEB 23 1999 Dener G. Sporks									

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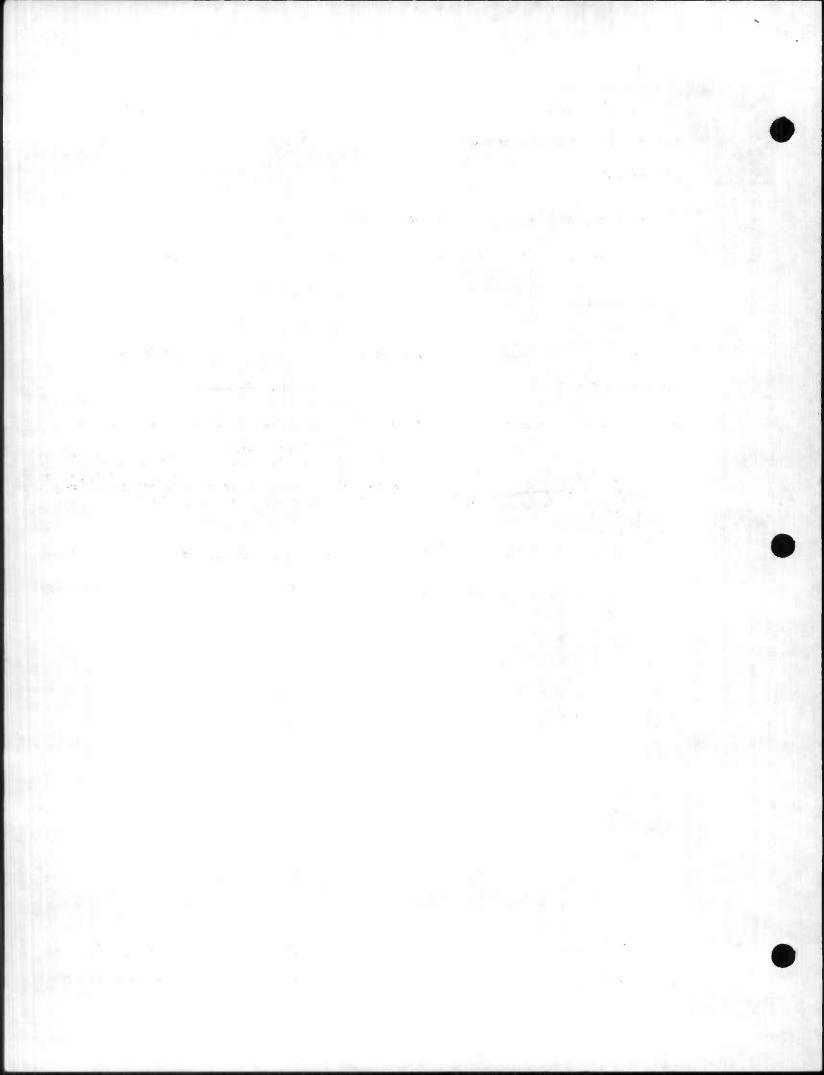
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ToB		Morris Segal						Yetta	Lesnick					
-	- -		e. Informant's Name/Reletionship (Type, Print) Percy Segal Brother 19b Mailing Addrass (Street and Number 10500 Rockville Pike								n. Stete. Zip	Code)		
		Percy Segal, Brot	her		10500	Rock	VII.	le Pike,	Apartme	ent '909				
		20e. Method of Disposition 1 X Buriat 2 ☐ Cremetion 3 E	Teamoval from		Place of Dispo cemetery, crem	sition (Ner	ne of ther plea	aryland ce) 2/23	Date /1999	20c. Location	- City or To	wn, Stete		
		4 Donetion 5 Other (Speci			ng Davi	d Mem	oria	al Garde	n	Falls Church, Virgini				
any injury or other tra		Signeture of Fundar Service Les Servi		eused tha dea	CT	TTN U	EDDI	ess of Fecility EW MEMOR L STREET ng, such es cerdie	IAL FUNI	ERAL HON WASHING	E, IN	C. D.C. 20 Approximete tntervel Between Onset end December 1988	0012 en	
Medical Examiner		Immedieta Causa (Finel diseese or condition resulting in daath) Sequentielly list conditions, if eny, leading to immediete ceusa. Entar Underlying Ceuse (Diseese or injury that inlitated events resulting in deeth) Lest	e. C C	Due to (3 R A Consequence of the consequ	uence of):	1S	RTERIC	SCLE	RUSI	5			
etached for use es														
lys!		Pert II. Other significant conditions of	contributing to de	eath but not res	sulting in the ur	derlying ca	ause giv	en in Pert I.		tobacco use c		the cause of c	leath?	
by Pt		KYPHOSCOL.	10515	, VI	75C4	417	-15		1 No 3 Probab			ably 4 Un	known	
Completed b		ASHD								s en eutopsy ormed?	eve co/	ore autopsy find pilebla prior to ppletion of ceus death?		
Comp									10	Yes 2 No	10	Yes 2 No)	
Be	1	25. Was cese refarred to medical exeminer?						26. Plece of De	eth (Check only	one)	1			
5 0		1 Yes 2 No	Hospitel: 1 🔲 I	npatient 2	ER/Outpetien	3□ DO	A Oth	ar: 4 Nursing F	lome 5 ☐ Res	idence 6 □Ot	her (Specify)		
nera on:	2	27. Menner of Deeth 1 A Naturel 5 Pending 2 Accident Investigation	n	of tnjury h, Dey Year)	28b. Time of Injury	M 2	8c. Injur Wor 1 🔲	y et k? Yes 2 □ No	28d. Describe	how injury occu	rred			
lied in by the fu		3 Suicide 4 Homlcide 6 Could not be determined 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify)							28f. Location City or To	(Street end Num wn, Stete)	ber or Rura	Route Number		
Medical Ce		29a. Certifier 1⊠ Certifying Ph (Check only 2 Medical Exam	niner: On the ba end menr	isis of axamine	owledge, deeth ation end/or inv	occurred e estigetion,	of the tin	ne, dete end place pinion, deeth occu	, end due to tha rred et the time,	date end place	enner as st and due to	ated. the ceuse(s)	116	
E CO	2	29b. Signeture end title		0		29c	. License	e number		29d. Date sign	d (Month, L	Day, Year)		
		sten	ues	Loss	on N	117	D	0588	5	07/6	20/9	9		
	3	0. Neme end eddress of person who	completed ceus	a of deeth (Iter	n 23a) (Type, f									
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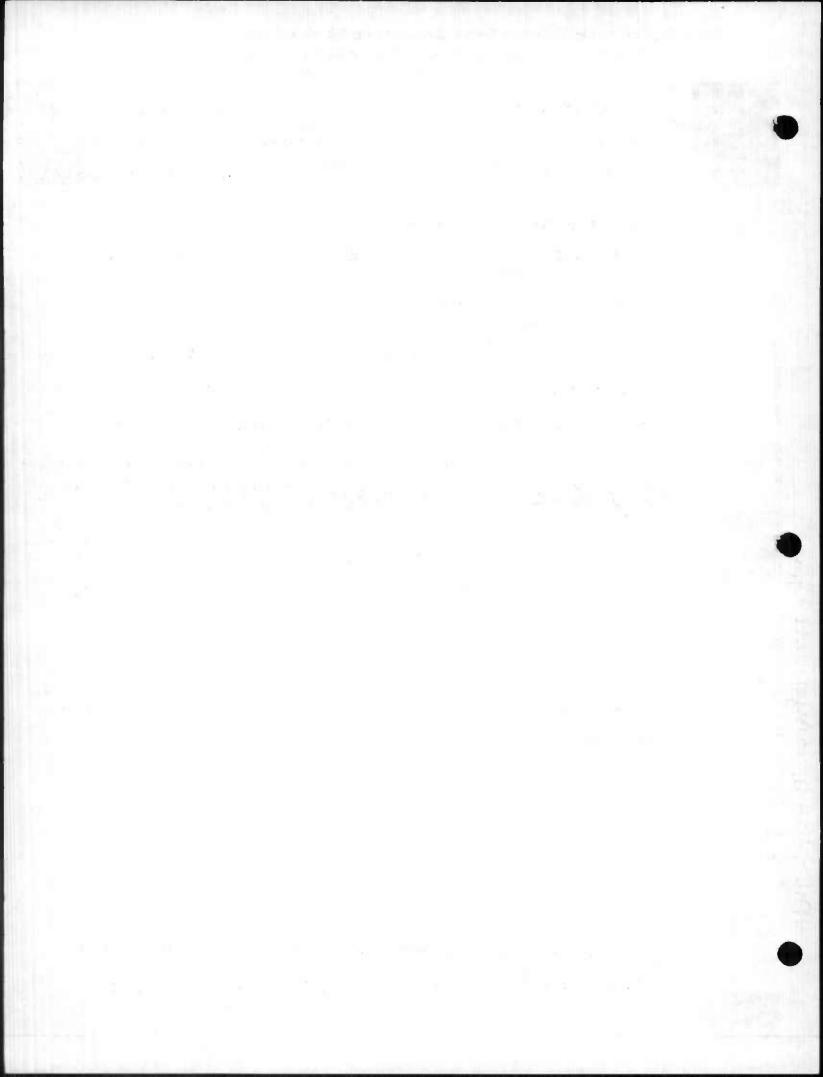
State of Maryland / Department of Health and Mental Hygiene 9 07266

Mary Sibold Mills 4a Facility Name (If not institution, give street and number) Montgomery General Hospital 5. Social Security Number 6. Sex 10 M 2 Sep		1. Decedant's Name (First, Middle,	Last)					2. Date of Death Month	Day	Year 3.	Time of Death				
As Facility Name (If an institution, give street and number) Nontgomery General Hospital 10 Social So		Mary Sibold Mil	ls								:55PM				
Montgomery General Hospital 5. See Sex 17-44-3395 6 Sex 91		4a Facility Name (If not institution,	giva street and nu	mber)			4b. City, Town, or I	ocation of Death	4c. County	of Death					
217-44-3395 100 Country 100 CBy, Town or Location 101 Ziu Code 102 City Code 103 Cities of What Country 102 City Code 103 Cities of What Country 104 Care American Indian. 105 Sale and Number 3310 N. Leisure World Blvd., #625 20906 105 Cities of What Country 107 Year Manage Copy (Specify Year or What Country) 107 Year Manage Copy (Specify Year or What Country) 108 National Country 109 Silver Spring 100 Cities of What Country 100 Line Season 10		Montgomery Gene	ral Hosp:	ital			Olney		Mont	gomery					
Substitute Sub	eral		3. Sex		last birthday)			8. Date of Birth			State or Foreig				
Top. State In the		217-44-3395	1□M 2⊠F	91	Yrs.	Months Days	nours win.	January	17,190	8 Virgi	nia				
Maryland Montgomery Silver Spring Maryland Montgomery Silver Spring 10p Citizen of White Country 10p Citizen of Whi		Usual Residence of Decedant													
The part and Number of What Country? 106. Zipt Code 107. Zipt Code 108. Zipt Code 109. Cattern of What Country? 109. Zipt Code 109. Cattern of What Country? 109. Zipt Code 109. Cattern of What Country? 109. Let sure World Blvd., #625 20906 110 Married Status 110 Married Sta	Е.,	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					side City Limits				
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Specify Spec	era		12. Was Dec	edent Ever in U				pecify Yas or No-							
Specify Spec	F							o Rican, etc.)	Blac	k, Whita, etc.					
Securities Sec			If Yes, Gi	/a	1	☐ Yas 200 No	Specify:		Specify						
18. Manher's Name (Figs), Modition, Surface (Note) Surface (Note) (Not					16a Deced	lent's Usual Occi	unation		16h Kind of Bu						
18. Manter's Name (Figs), Modils, August 20	iet	(Specify only highast	grade completed)		(Give I	kind of work don	e during most of wor	king		y					
18. Mether's Nama (Fright, Models, Austral) 18. Mailing Address (Street and Number or Plans I Robust Number, City or Town, State, Zip Code) 11.29 Ashland Avenue, Santa Monica, CA 90405 12.29 Ashland Avenue, Santa Monica, City or Town, Salte) 12.29 Ashland Avenue, Santa Monica, City or Town, Salte) 12.29 Ashland Avenue, Santa Monica, City or Town, Salte) 12.29 Ashland Avenue, Santa Monica, City or Town, Salte) 12.29 Ashland Avenue, Santa Monica, City or Town, Salte) 12.29 Ashl	di o	Elemantary/Secondary (0-12)							Own Hen	200					
John L. Sibold Selection		17 Father's Name (First Middle 1		4	nomen	laker	18 Mother's No.	na (First Middle I							
19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zp Code) Marry K. Mills / Daughter 1129 Ashland Avenue, Santa Monica, CA 90405 120 Acidstant 120 Ashland Avenue, Santa Monica, CA 90405 120 Acidstant 120 Acidstant 120 Ashland Avenue, Santa Monica, CA 90405 120 Acidstant 120 Ac	traumatic		131/				io, mothers Nar	Johnston	MBINDC Hebrar	6/					
Mary K. Mills/ Daughter 20a Mahnd of Disposition Date 20b Location - City or Town, State															
20a. Mathod of Disposition 20a		19a. intormant's Name/Ralationshi	et and Number or Ru	ıral Route Number,	City or Town,	State, Zip Code	9)								
Bethesda		Mary K. Mills/	Daughter				Avenue,								
A Donalion S Onther (Specify) Montgomery Crematorium, Inc. Bethesda, Maryla				20b.	Place of Dispos	sition (Name of	ace)Tohana	Date :	20c. Location -	City or Town, S	State				
21. Signature of Foreral Several Locuses 22. Name and Address of Facility Robert A. Pumphrey Funeral Bethesda-Chevy Chase, Inc. 7557 Wisconsin. Bethesda-Chevy Chase, Inc. 7557 Wisconsin. Bethesda, Maryland 20814-3501 Bethesda, Maryla		1 Burial 2 Cremation 3	Removal trom	Stata	ntaomer	v Crema	torium T	y23,1999	Retheed	a Mary	hand				
Bethesda - Chevy Chase, Inc. 7557 Wisconsin. Bethesda, Maryland 20814-3501 Appointment of the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Bethesda, Maryland 20814-3501 Bethesda 20814-350			1	110		_									
Settle S	1	22. Name and Addrass of Facility Robert A. Pumphrey Bethesda-Chevy Chase, Inc. 7557 Wis													
Immediate Cause (Fhal disease or condition resulting in death) Due to (or as a consequence of): Congustive Cause (plasase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Du		MAIN				Bethe	sda, Mary	land 2081	4-3501						
Immediate Cause (Fhal disease or conditions contributing in death) Due to (or as a consequence of): Congustive Cause (Phal disease or conditions can be a consequence of): Congustive Cause (Disease or injury thinlated events resulting in death) Last Due to (or as a consequence of): Du		23a. Part1 Erger the disease, or compared to the list of	omplications that only one cause on e	aused the	Do not ente	er the mode of d	/Ing, such as cardia	or respiratory arre	est,	Appr	roximate vai Between				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury probability and interest of the cause (Disease or injury probability and interest of the cause (Disease or injury probability and interest of the cause (Disease or injury probability and interest of the cause (Disease or injury probability and interest of the cause (Disease or injury probability and interest of the cause (Disease or injury and injur	n	()00()								Ons	et and Death				
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributions to the cause contribute cause contribute to the cause contribute to the cause contribute to the cause contribute cause contribute cause contribute to the cause contribute to the cause contribute cause contribute to the cause contribute cause cont		Cause (Disaasa or injury	c							-					
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25. Was case retained to medical examiner? 26. Piace of Death (Check only one) 27. Manner of Death 1 Natural 2 Accidant 3 Suicide 4 Homicide 28. Piace of injury 4 Norming Home 5 Residence 6 Other (Specify) 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28d. Dascriba how injury occurred 28d. Dascriba ho			m d							i					
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25. Was casa ratarred to medical examiner? 1	S	Part II. Other significant condition	s contributing to d	eath but not ra	sulting In tha ur	ndarlying cause (jiven In Part I.	23b. Dld to	bacco usa co	ntributs to the	csuse of death				
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1 Yes 2 No	Be		11.					ath (Check only on	Θ)						
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29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year,	atio	in the state of		in, Day rour,	Inquiry										
29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year,	FIC.	datamin	an ZBa, Place	ot injury - At h	ome, tarm, stre	eet, tactory, offic	9	28t. Location (St	reet and Numb	er or Rural Rou	ite Number,				
29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year,	ert	4 Homicide	build	ng, atc. (Space	fy)			City of Town	, State)						
29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year,	0	29a Certifier 1 Certifying	Physician: To the	beet of my kn	wieden daath	occurred at the	time date and place	and due to the co	usea(e) and me	nner se etated					
29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year,	lica	(Check only 2 Medical Ex	caminer: On the b	asis of examina	ation and/or inv	estigation, in my	opinion, death occu	rred at tha tima, d	ata and place,	and dua to tha	causa(s)				
			and man	ner stated.		00-11	and a sumbar		Od Data sissa	d (March Day	Vand				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	~														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		witerus	mg			230	812	7	26 Juan	121,1	689				
		30 Name and address of person w	ho completed caus	se of death (Ite	m 23a) (Type. I	Print)			(1					
[NATURON O- HERRIS 3705 North Leisun Wood Koulevas) live Lovin a Mariland 20 96					1 . 3 50 -0 1										



State of Maryland / Department of Health and Mental Hygiene O O

			A Developed New Arms and Arms			C	ertifica	ate of	Death		Reg. No.		I Im	
	Physici	an	Decadant's Nama (First, Middla, Last, Decadant A							2. Data of Do Month	Month Day			a of Death
3	/Medic		Raymond A 4a. Fecility Nama (If not institution, give						4b. City, Town, or L	Februa			8:45	5 AM
	Examir	ner	Suburban Hospital		,				Bethesda	ocation of Dea		y of Death		
		H	5. Social Security Number 6. Sec		na (In vis	. last birthde	av) If Un	der 1 Yeer		6 Date of Bi		tgome		la or Famian
	Funeral Director			M 2□F		37 Yrs	Month	hs Days		6. Dete of Bi (Month, Di Feb. 1	ay, Year) 5, 1912	Wash		te or Foraign
	should be filled within 72 hours efter deeth with the Maryland nd Mental Hygiena. marked other than "natural", or items 23a or 28a-f show urnatic event, the Medical Examina; must be notified at	7	10a, Stata 10b. County			ity, Town or						1		City Limits
	the M	ecto	Maryland Montgome:	ry	Ве	thesd		7'- 0-4				147		59 2 2 140
	3a or	ig D	5912 Walton Road					Zip Coda 20817			10g. Citizan of United		•	
	vurs efter deeth with al', or items 23e or Examinet must be	by Funeral Director		12. Was Decedeni Armed Forcas	?	J,S. 1	3. Was De If Yas, s	cedant of I	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yas or No Rican, atc.)		ce - Americ ick, White,	an Indian,	,
020	al, or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYas 2 II If Yas, Giva Yaar or Detas:		II	1 🗆 Yas	2 ☑ No	Specify:		Speci	fy: V	Vhite	
21215-0020	3 within 72 hours jiena. r than "natural", ilis Madical Exi	Be Completed	15. Decedant's Edu (Specify only highest grade	cation a complated)		16a. De	iva kind of	sual Occu work dona	pation during most of work	ing	16b. Kind of E	Businass/Ind	dustry	
	d within giena. F than	omo	Elementery/Secondary (0-12)	College (1-4or	5+)		ter (U.S. Postal				vice
Maryland	I be filed ntal Hygi ed other event, II		17. Fether's Neme (First, Middla, Last)						18. Mothar's Nam			ma)		
T.	should nd Mei marke	To	Benjamin C. Milst 19a. informant's Name/Ralationship (Ty.			19b. Ma	ailing Addr	ass (Stree	Louise (Stata Zio	Coda)	
	trains		Miriam H. Milstead						Road, Betl				,	
ore,	. Pages 1 and 2 should be filed wiment of Heelth and Mental Hygie tant: If item 27 Is marked other tury or other traumatic event, the		20a. Mathod of Disposition 1 ☒ Burlal 2 ☐ Cramation 3 ☐ R		20b.	Place of Discometery, of	sposition (f	Nama of or othar pla	Feb. 27,	Data 1999	20c. Location			
litim	permit. Pages Depertment of Important: If it any Injury or o		4 □ Donation 5 □ Othar (Spacify) 21. Signetura of Funaral Sarvice Licanse	90		te of	Heav	ren Ce	emetery		Silver	Sprin	g, Ma	ryland
Baltimore,	Depe Impo		Karf Son	_	M00	198	Robert 7557 Bethe	t A. Wisco sda.	ess of Facility Pumphrey Onsin Aver Maryland	Funeral nue 20814	L Home/E -3501	ethes Cha	da-Cl ase,	nevy Inc.
	Obveriales		23a. Part1. Enter tha disaasa, or compli shock, or keert feilura. List only or	cations thet cause ne ceusa on aach i	d tha daa ina.	th. Do not	anter tha m	noda of dyl	ng, such as cardiac	or respiratory	arrast,		Approximintarval E	nate Between
	Physician /Medical		Immediata Causa (Final disaasa or condition Congestive Heart Failure										2 hou	
ho	Examiner	Examiner	rasulting In death)			or es e con						1	2 1100	115
3/	be isi			Seps	is								1 day	7
71 6	execut in end tal-trer	Exan	Sequentially list conditions, if any, laeding to immediate cause. Entar Undarlying Causa (Disease or injury that initiated avants Dua to (or es e consequence of):											
68760,	tificate be executed g physician end as the burial-trensit	edicai	Causa (Diseese or injury that initiated avants rasulting in deeth) Last Dua to (or es e consequence of):											
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E B	death cert a attanding d for use	iciai	Part II Other significant conditions cor	tributing to death h	nut noi ras	culting in the	a undartuin	o course di	von in Part I	225 Did	tobacco use o	antelbute to	the caus	o of death?
200	The law requires thet tha death cer te hes been signed by the attandir bage 2 should be detached for use	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Coronary Artery Disease								23b. Did tobacco use contribute to the cause of 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒			
Sp.	uires the signer	d by	Cangrana Foot							24a Was	s en autopsy	24b. Wa	ara autops	sy findings
Record	aw requires been s	Completed	Gangrene Foot							perf	ormed?	CO	allabla prid mpletion o daath?	or to
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/tag	certificate rector, pag	Be	25. Was casa rafarred to medical examinar?						26. Placa of Daat	h (Chack only	ona)			
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	inding Physeth. eth. r: After this	ation:	27. Mannar of Death 1 ☑ Naturel 5 ☐ Panding 2 ☐ Accident Invastigation	28a. Data of Inju (Month, Da	iry iy Year)	28b. Time Injur		28c. Inju Wo	nyai vrk?]Yes 2 □ No	28d. Dascribe	how Injury occu	rred		
Division	or Atten aftar deet Director:	Certification:	3 Suicida 4 Homlolda 6 Could not be determined 28a. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Streat City or Town, St									ber or Rura	/ Route N	u <i>mber</i> ,
M	Hospita 4 hours Funeral taly filled	edicai C	29e. Certifiar 1 Certifying Phya (Check only one) 2 Madicai Examir	ner: On tha basis o	f axamina	owladga, da ation and/or	ath occurre	ed et tha ti	ma, data and pieca, opinion, death occur	end dua to the red at tha tima,	ceuse(s) end m	enner es si , end dua to	eted.	e(s)
	To the within 2 To the compla	Mec	29b. Signature and title of certifier	and mannar st	ated.			29c. Lican:	sa number		29d. Data sign	ad (Month,	Day, Year)
0	241		Almm	-10	0	_	_	039	064		Februa			
			30. Name and addrass of parson who co											
			James M. Salender,	M.D. 1	1119	Rock	ville	Pike	, Rockvil	le, Ma:	ryland	20852	2	
71-17	Sta	te	31. Date filad (Month, Day, Year)	qq 32. Registr	rar's Slon	ature	9.	Locu	Es/					



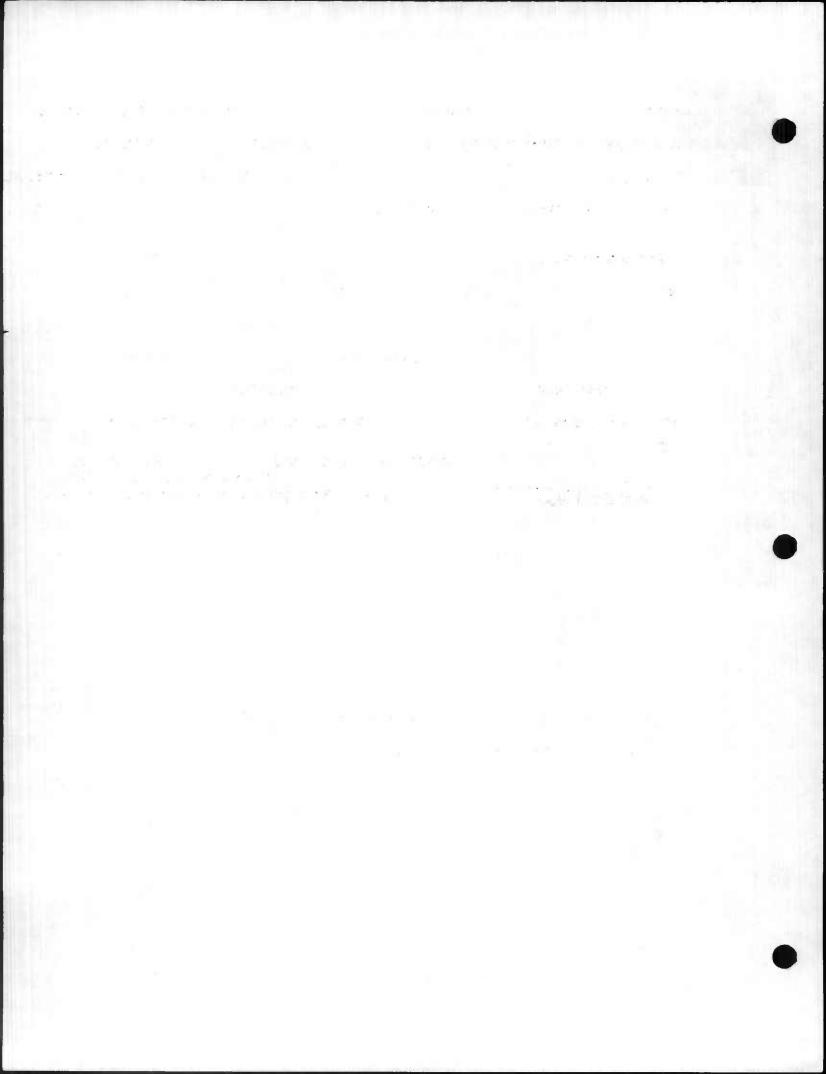
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer **Physician** FEBRUARY 24, 1999
ocation of Death 4c. County of Death MINKOFF 7:45 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Yeer Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 1 M Z **Funeral** Min. Days Months Hours Director 578-48-5680 SEPTEMBER 1, 1922 WASHINGTONDO the Maryland 10d. Inside City Limits 10a. Stete MD 10c. City. Town or Location r 28a-f ahow MONTGOMERY ROCKVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with r than "natural", or items 23s or the Wedical Examinet must be r UNITED STATES 6160 MONTROSE ROAD 20852 Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or iter Never Married 2 Married Specify: WHITE 1□ Yes 2 Baltimore, Maryland 21215-0020 Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNAVAILABLE UNAVAILABLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) SUE LEVIN (GUARDIAN) 800 SOUTH FREDRICK BOULEVARD GAITHERSBURG MD 20877 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

Buriel 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, Stete permit. Page Department o Important: If eny Injury or once. = 6 4 ☐ Donation 5 ☐ Other (Specify) 2/26/99 CHESSED SHEL EMMES CEM. WASHINGTON DC 21. Signature of Funeral Servica Licansee 22. Name and Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPEL 1170 ROCKVILLE PIKE ROCKVILLE MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Atherosclerotic ueans Examine Due to (or as a consequence of) Examiner the death certificete be executed physicien and s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of) signed by the a d be detached f Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 □ Probably 4 Unknown hyperlipidemia, 1 Yes 2 No Division of Vital Records, by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? s certificate has b 2 X No Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred After 1 Neturel 5 Pending 1 ☐ Yes 2 No investigation 2 Accident hours after deal 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homleide n 24 hou. The Funeral Disò Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and menner stated. 29a. Certifler edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Patricia loms 31. Date filed (Month, Day, Year) FEB 26 State

Registrar

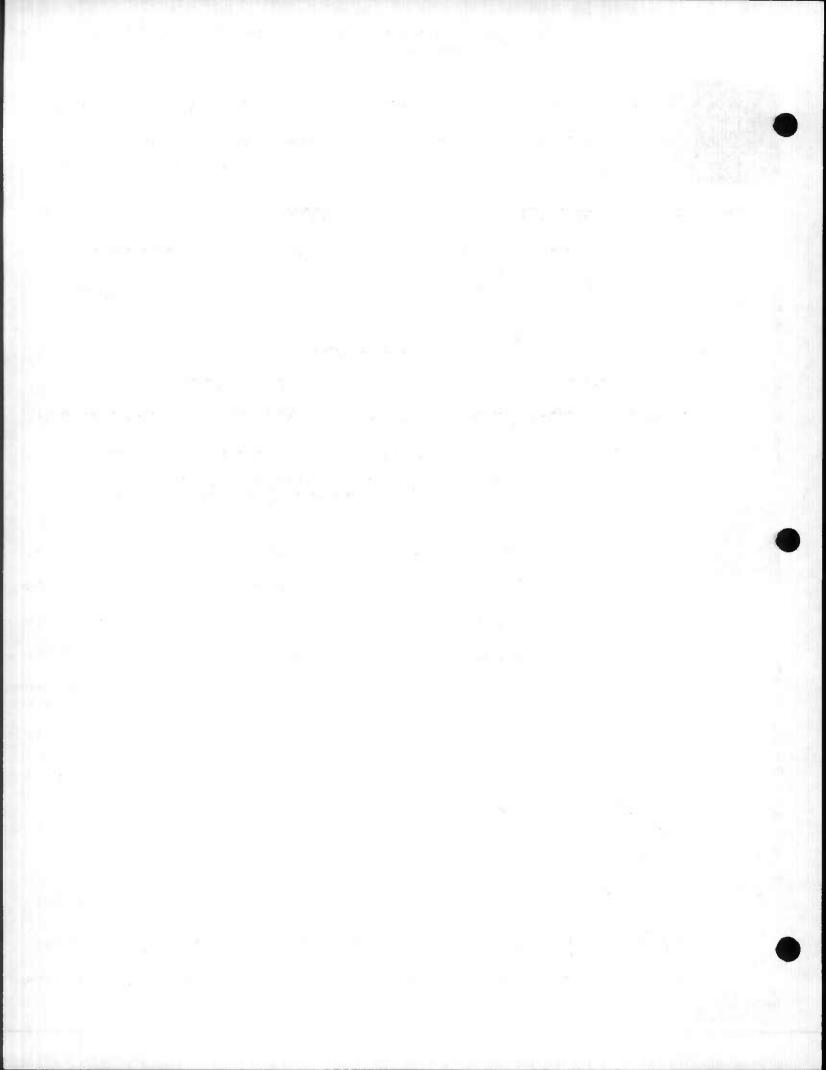


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death Physician FEBRUARY **EMMETT** MITCHELL 23.1999 08:34 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Shady Grove Adventist Hospital Rockville MD Montgomery 5. Sociel Security Number 6. Sex 120 M 2□ F If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) FEB. 2, 1915 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months Deys Min 84 Yrs. Director 358 18 0165 Usuel Residence of Decedent ILLÍNOIS 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD. MONTGOMERY MONTGOMERY VILLAGE 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 "natural", or itema 23a 19310 CLUB HOUSE ROAD #612 20886 UNITED STATES Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene.

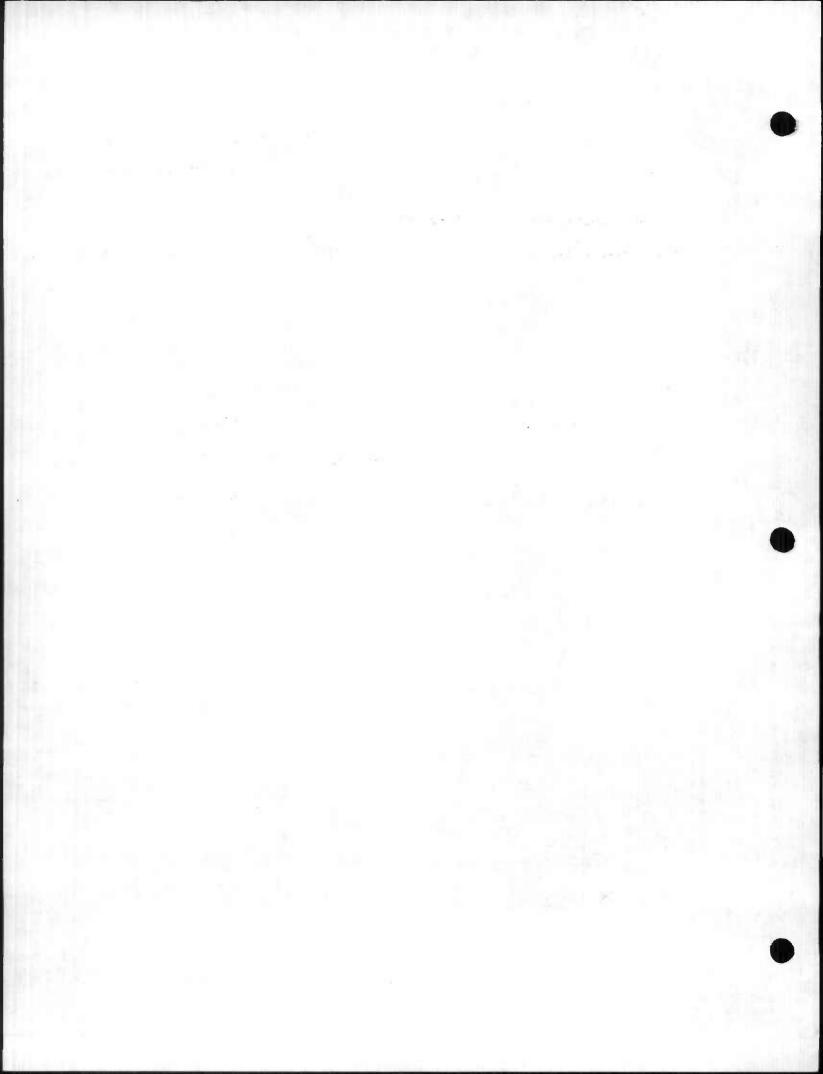
The process of the permitten of the pe Bleck, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married アBaltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: WHITE py 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) RAILROAD ADMINISTRATOR 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) JOHN P. MITCHELL MAE CLENNON 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH J. MITCHELL, WIFE 19310 CLUB HOUSE ROAD, MONTGOMERY VILLAGE, MD. 20886 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) METROPOLITAN CREMATORY 2/24/99 ALEXANDRIA, VA. 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel CARDIO - PULMONARY FAILURE 15 MIN. disease or condition resulting in death) Examiner Due to (or es e consequence of): 24 HOURS CEREBRO VASCULAR ettending physician and for use as the burial-trensit The law requires that the death certificete be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of) Records, P.O. Box 68760, SEPSIS Physician/Medical Due to (or es e consequence of): ACUITE CHOLE CYSTIT'S Pert II. Other significent conditione contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? peen : 2 1 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) 1 ☐ Yes 2 No 27. Menner of Deeth Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28e. Date of Injury (Month. Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1. Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29e. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D31720 FEBRUARY 23, 1999 ninin 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 6-23; GATHERSBURG, MD. 20886 19241 HERBERT JUARBE MINTGOMERY VILLAGE AVE -31. Date filed (Month, Day, Year) 32. Registrer's Signeture State FEB 26 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Bernice Balch. February 22, 1999 Moore 10:20 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Bedford Court Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Devs Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthpleca (State or Foreign Country) **Funeral** Deys Months 1 □ M 2 □ F Yrs. 579-44-4561 90 Director July 13, 1908 Massachusetts Usuel Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow! 1 ☐ Yas 2 ☐ No 25a-f Directo Maryland | Montgomey Rockville 10a. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 14019 Drake Drive 20853 United States Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2∑ No If Yes, Give Yeer or Detes: Herra. Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Merital Status Black, White, etc. atte 1 ☐ Never Merried 2 ☐ Merried à Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ YNo Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Teacher Private School 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Pages 1 and 2 should be fit ment of Health and Mental H tart: If them 27 is marked off Jury or other traumatic even Be Percy I. Balch Amy Moulton 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moulton H. Schwab 14019 Drake Drive, Rockville, Maryland (son) 20853 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from Steta permit. Page Department of Important: If any injury or 2-23-99 Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral Services, P.A. 21. Signeture of Funarel Sarvice Licensee arola o Qr 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel 2-3 DAYS diseasa or condition resulting in deeth) TOOT Examiner Examiner 2-3 yesas ementig ician and burial-transit the deeth certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Undarlying Couse (Diseese or Injury that initiated evants resulting in daeth) Last Due to (or as e consequence of): Box 68760, Physician/Medical Due to (or as a consequance of): P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown by Records, 24a. Wes an autopsy performed? 24b. Were eutopsy findings evailable prior to Completed completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital or Attending Physician: director Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division After 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident Investigation after death Director: 8 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide filled in 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner es stated.

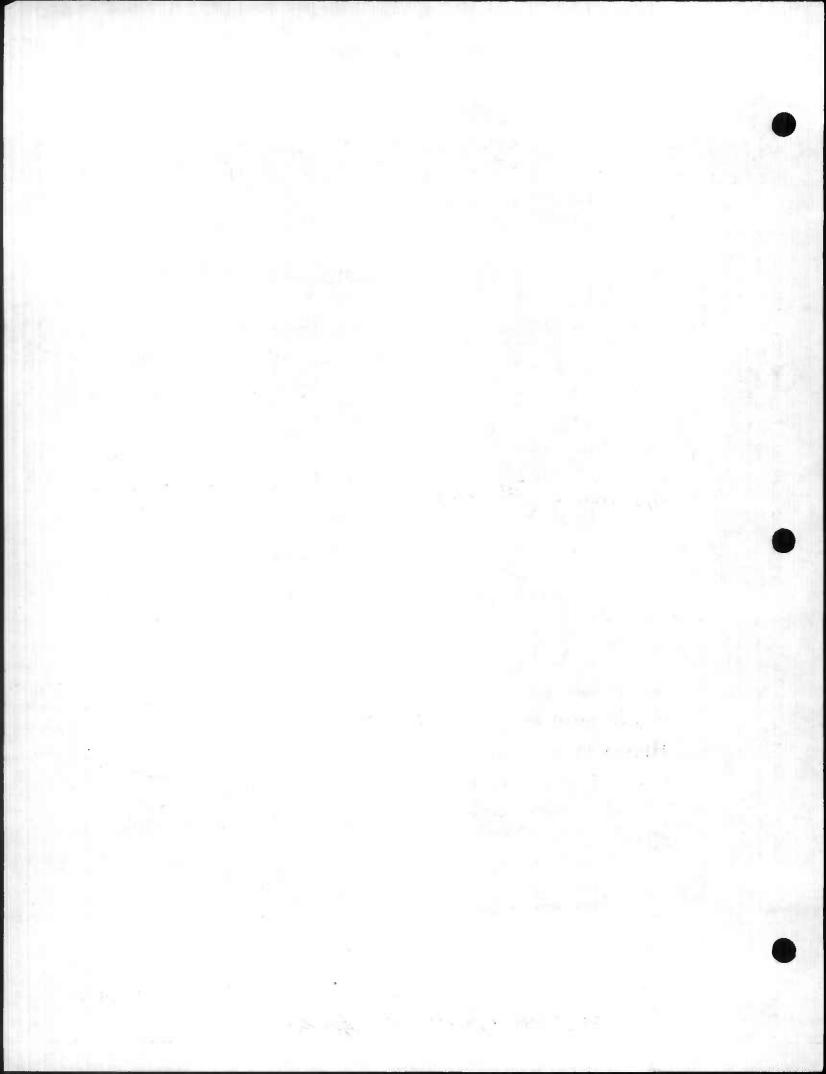
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier Medical (Check only one) within 2. To the F 29b. Signature and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 18/1/ PRINCE PHICIP DR # 212 OLVE OLNEY. MD 20832 GAURANG 31. Dete filed (Month, Day, Year) FEB 24 32. Registrer's Signature State Registrar



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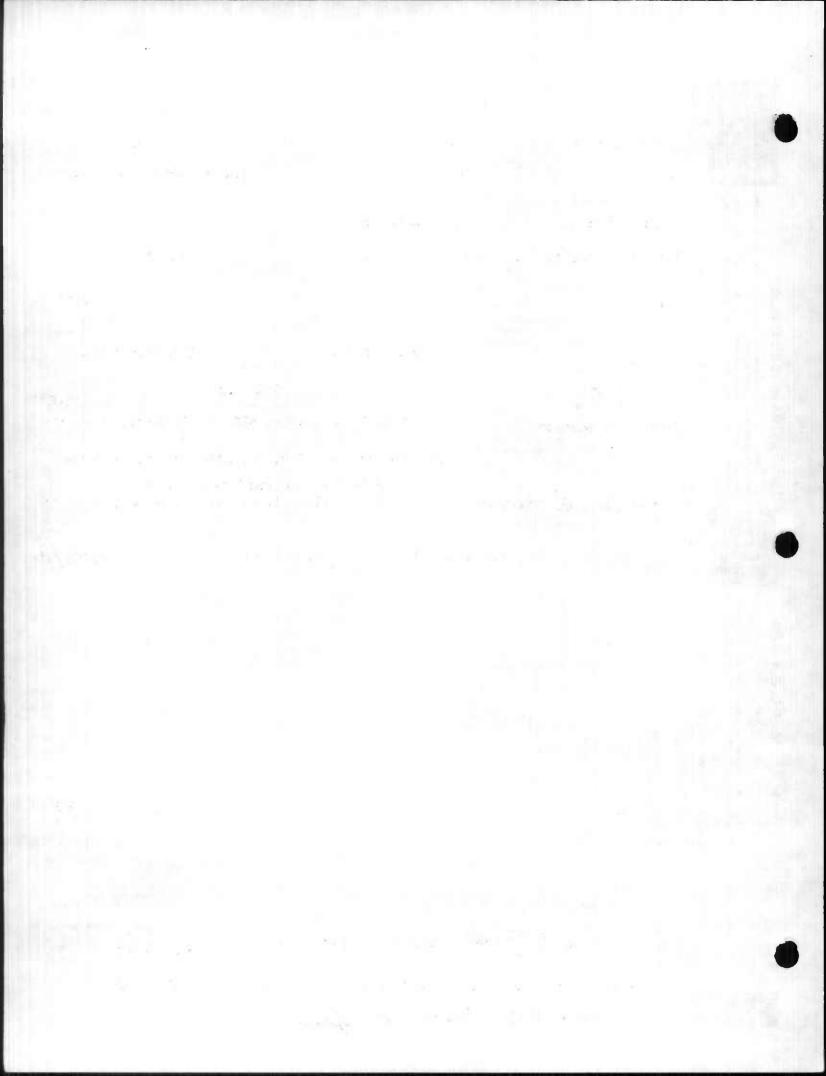
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C = N L	19a. Informant's Name/Relationship (I	Type, Print) SON				Route Number, (City or Town, State,	Zip Code)	
Ore Hear	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removel from State	Place of Disposition cometery, cremetory	(Name of y or other plea	9)	Dete 20	EASTON, M		
Baltim pemit. Peg Department Important: I any Injury o	21. Signature of Funeral Service Licen		22. Nar	ne end Addres	s of Fecility			HOME, P.A.	
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he Hoe in 24 h he Fun spietely	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	ition and/or investig	ation, in my or	pinion, deeth occurre	d et the time, dat	e end plece, and du	e to the cause(s)	
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State Registrar	31. Date filed (Worth, Day, Year)	32. Registrar's Signa	ature 4	1			,		

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State of Maryland / Department of Health and Mental Hygiene q q 07272

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an/Medical Examiner	Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last	a. <i>Cas</i> b	Due to (or as a Due to (or as e	consaquanca d	of):					1.1.40
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State of Maryland / Department of Health and Mental Hygiene

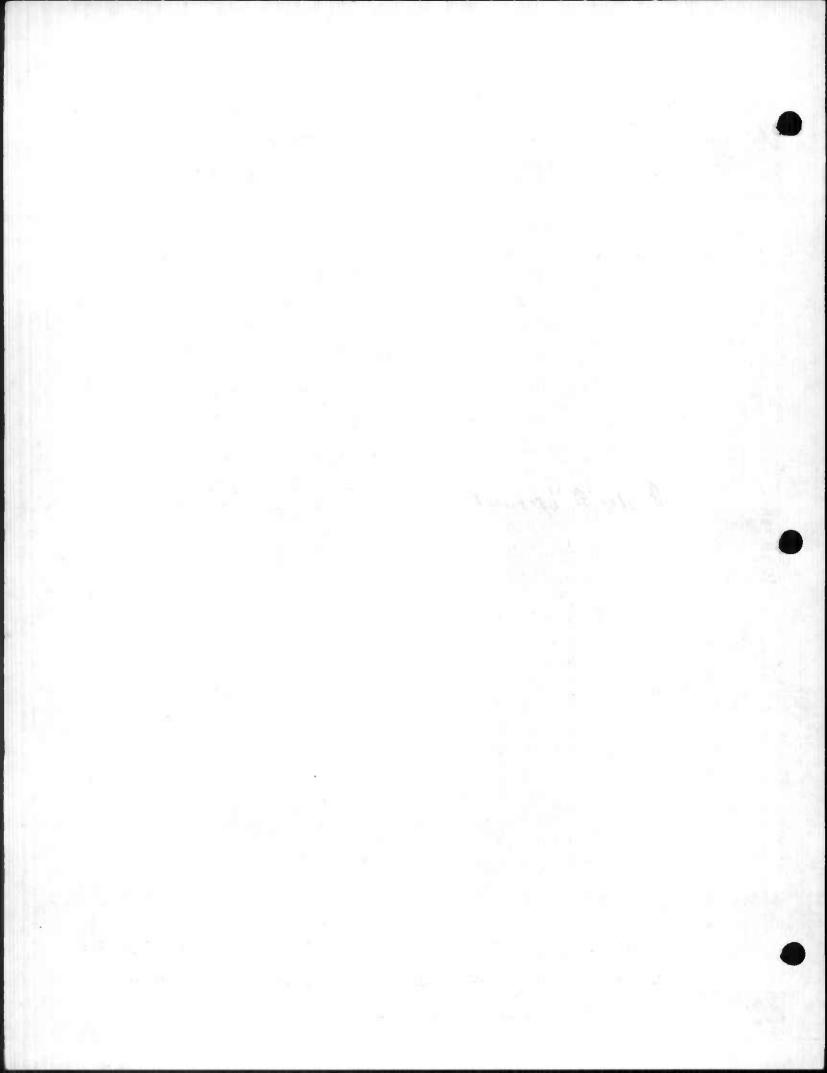
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Janet Mosby (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 18 percent) 20b. Location - City or Town, Stetle 20b. Method of Disposition 20b. Place of Disposition (Name of 18 percent) 2/24/99 20b. Location - City or Town, Stetle 2/24/99 20b. Location - City or Location - City or Location	2		Henry										
20s. Method of Disposition 20s. Place of Disposition (Name of Commentary) 20s. Place of Disposition (Name of Commentary) 21 Signeture of Funeral Segmentary (Street Property) 22 Name and Address of Facility 23 Sent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 22 Sent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 23 Sequentially list conditions, feet, leading to manage and other conditions. 24c. Was an autopsy performed? 25c. Was asset referred to medical examiner? 25c. Was asset referred to medical examiner. 25c. Was a sustopsy performed? 25c. Was a sustopsy linding examiner? 25c. Was a sustopsy performed? 25c. Was an autopsy performed? 25c. Was a sustopsy performed? 25c. Was a			The same of the sa										
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State of Maryland / Department of Health and Mental Hygiene

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Be	2	Wes cese reterre examiner?	ed to medical	Hoopital				0.1	26. Place of Dee	eth (Check only	one)				
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Certification:		1 Neturei 2 Accidant 3 Suicida	5 ☐ Pending investigation 6 ☐ Could not b	(Month	n, Dey Year)	28b. Time of Injury	М		? /as 2 No	28d. Describe					
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fedical		one)	Certifying Ph	ysician: To the b ninar: On the bas end menn	sis of exemine	owledge, daeth etlon end/or inve	occurred et the estigation, in	ne tim my op	e, date end plece Inlon, deeth occu	, end due to tha rred et the time,	cause(s) dete end	end me plece, o	enner es stet end due to th	ed. ne cause(s)
Medical Certification: To Be	2	9b. Signature end t	itle of certifier	•	1				number				d (Month, De		
	3/	Nemo and add	Me	rust	of death ("	n ((2a) (T		289	910	I	EBRU	JARY	24,1	999	
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DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** LORETTA E. MCKENZIE FEBRUARY 18, 1999 03:00 AM /Medicat 4h City Town or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Sacred Heart Hospital Cumber 1 and Allegany If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Dey, Oct 21, 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2√2F 213-22-3901 87 Yrs Director Usuat Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show 1 Yes 2 No Director Allegany Cumberland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 869 Gephart Drive 21502 USA death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒No þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Retired Cumb. Blouse Factory 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: If them 27 is marked oth eny injury or other treumstic event apple. J. Gibson Starkey Bertha (McBee) 19a. Informant's Name/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Francis S. McKenzie - husband 869 Gephart Drive Cumberland MD 21502 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 02/20 Hillcrest Memorial Park Cumberland MD 22. Name and Address of Fecility Scarpelli Funeral Home, P.A. Cumber 1 and

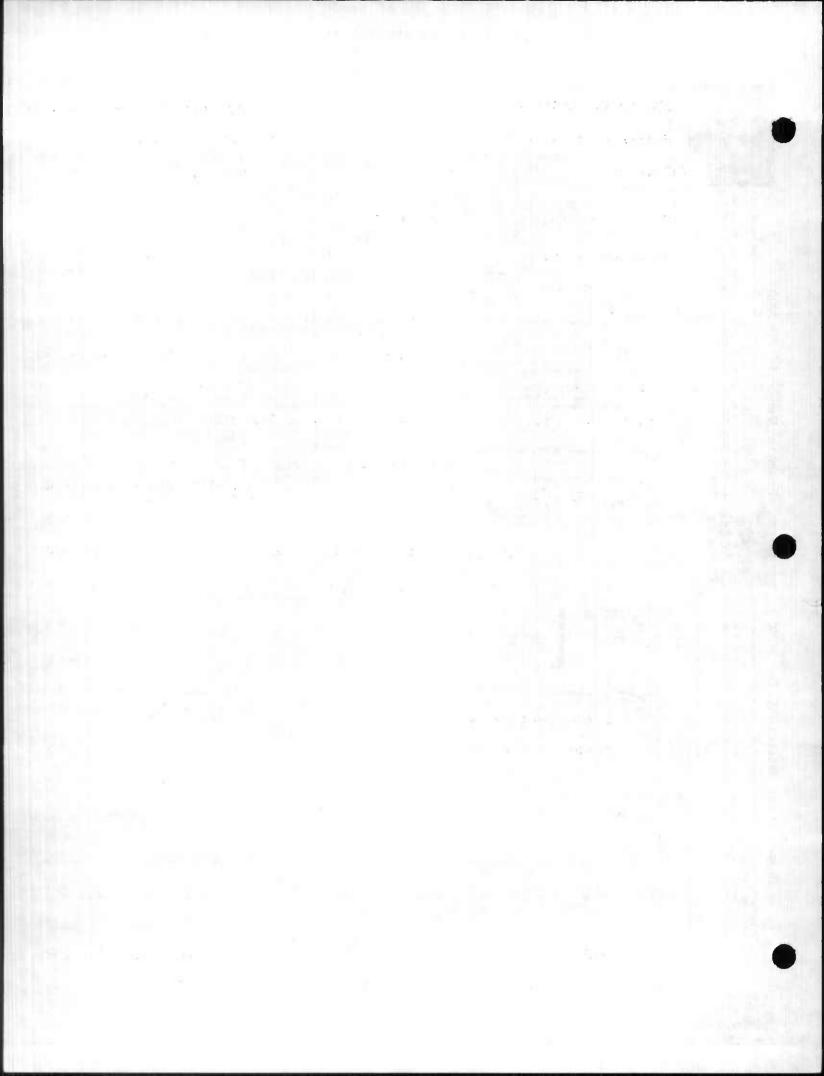
23a. Part 1. Enter the disease, or complications the feused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Cumberland MD 21502 Intervel Between Onset end Death **Physician** fmmediate Cause (Final disease or condition resulting in death) /Medical ONE DAY VASCULAR TONOMOUSIS CENEBUAL Examiner Due to (or as a consequence of): TEN YEARS Physician/Medical Examiner ATRIAL FIBRILLATION the death certificate be executed physician end s the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of) Box 68760, thet initieted events resulting in deeth) Last Due to (or es e consequence of): 98 USB signed by the a d be deteched f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ☐ Unknown SENILE DOMENTIA Division of Vital Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of death? should Completed CONGESTIVE HEMMET FAILURE certificete has page 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 70 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After Hospital or Attending 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death.

I Director: A in by the fu 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature end title of ca 29d. Date signed (Month, Dey, Year) FEBRUARY 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) , Lavale, MD 2/502 James Moen nu 1068 National Highway 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Edward Kenneth McAlpine FEBRUARY 15, 1999 catlon of Daath 4c. County of Death 2017 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Sacred Heart Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) June 1927 Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 □ F 216-22-7188 71 Yrs. Usuei Residenca of Decedent 10e State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 0 No Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 15570 Lower Georges Creek Road 21539 USA 12. Wes Decedent Evar in U.S. Armed Forces? 1 ☑ Yas 2 ☐ No WWII If Yes, Give Year or DetesUS Army Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bieck, White, etc. 1 Never Marriad 200 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b Kind of Business/Industry Coitege (1-4or 5+) Eiementary/Secondary (0-12) Labor Glass 18. Mother's Name (First, Middla, Maidan Sumama) 17. Fether's Name (First, Middle, Last) Alexander Bell McAlpine Anna Marie Hausrath 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Rose Marie McAlpine 15570 Lower Georges Creek Road Lonaconing MD 21539 wife 20b. Plece of Disposition (Name of cametery, crematory or other placa) Feb. 18 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Sunset Memorial Park 1999 Cumberland MD 22. Nama and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 21. Signature of Funerel Service Licansee M' Kengce 6 ames 8 E. Main Street Lonaconing, MD 21539 23e. Peril: Ehter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory errest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 20 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24e. Wes en autopsy Gastro in textina completion of cause of death? Spiranes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Placa of Deeth (Check only one) Hospitai: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

any injury or

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

item 27 is marked other then "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter or Dependment of Health end Mental thygiene. Important: If item 27 is marked other than "natural", or iter

Baltimore, Maryland 21215-0020

with the Marylend

death

Examiner physician end the burief-trans physician Physician/Medical as esn 20 Completed hes

Be

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Certification:

law requires that the death certificete be exer certificate or Attending Physician: After this funeral 24 hours after death.
Funeral Director: Al filled in by Hospital

Division of Vital Records, P.O. Box 68760,

Medical within 2 nes Registrar

25. Was case referred to medical exeminar? 1 Yes 2 No 27. Menner of Deeth 1 Naturel 2 Accident 3 ☐ Sulcida

4 Homicide

(Check only one)

29b. Signatura end titia of certifier

29a. Certifier

5 Pending investigation 6 Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of

28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d Dascribe how Injury occurred 1☐ Yes 2☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Phyalcien: To the best of my knowledge, death occurred at the time, date end pteca, end due to the ceuse(s) end menner as stated.

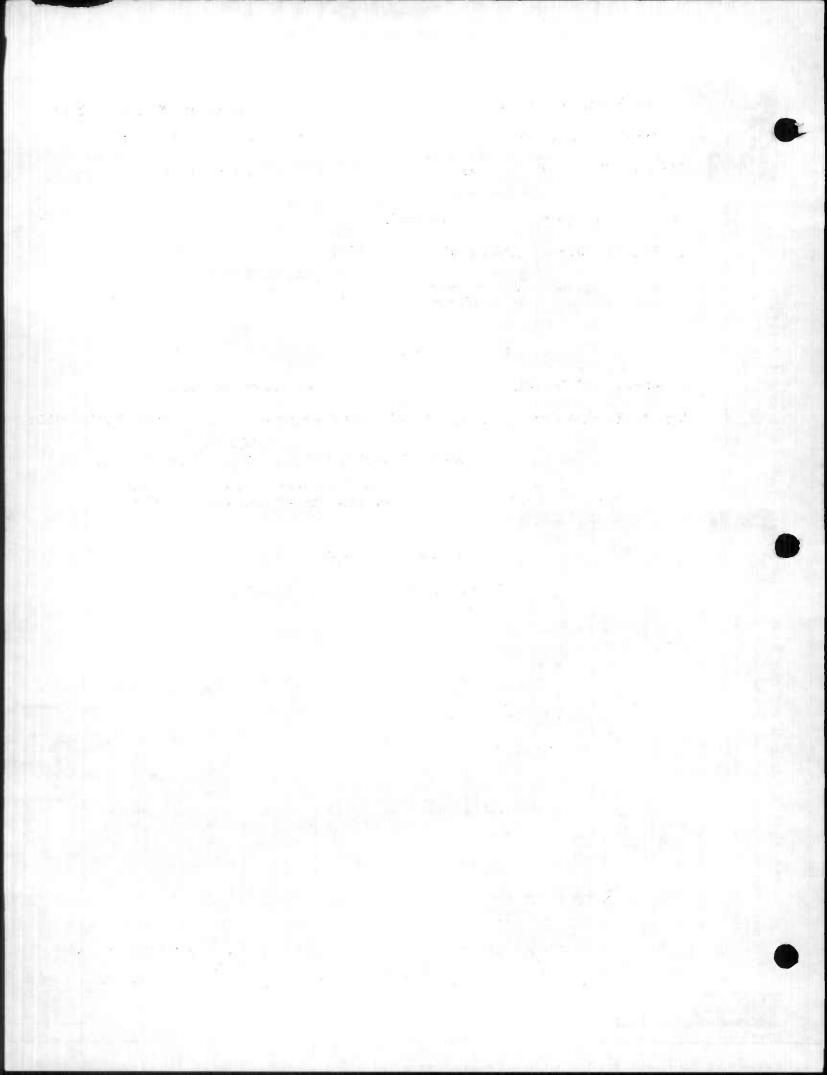
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) and marrier steted. 29d. Date signed (Month, Day, Year) 29c. License number

FEBRUARY 17, 1999

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registant Signature

31. Dete filed (Month, Day, Year) FFB 2 2 1999



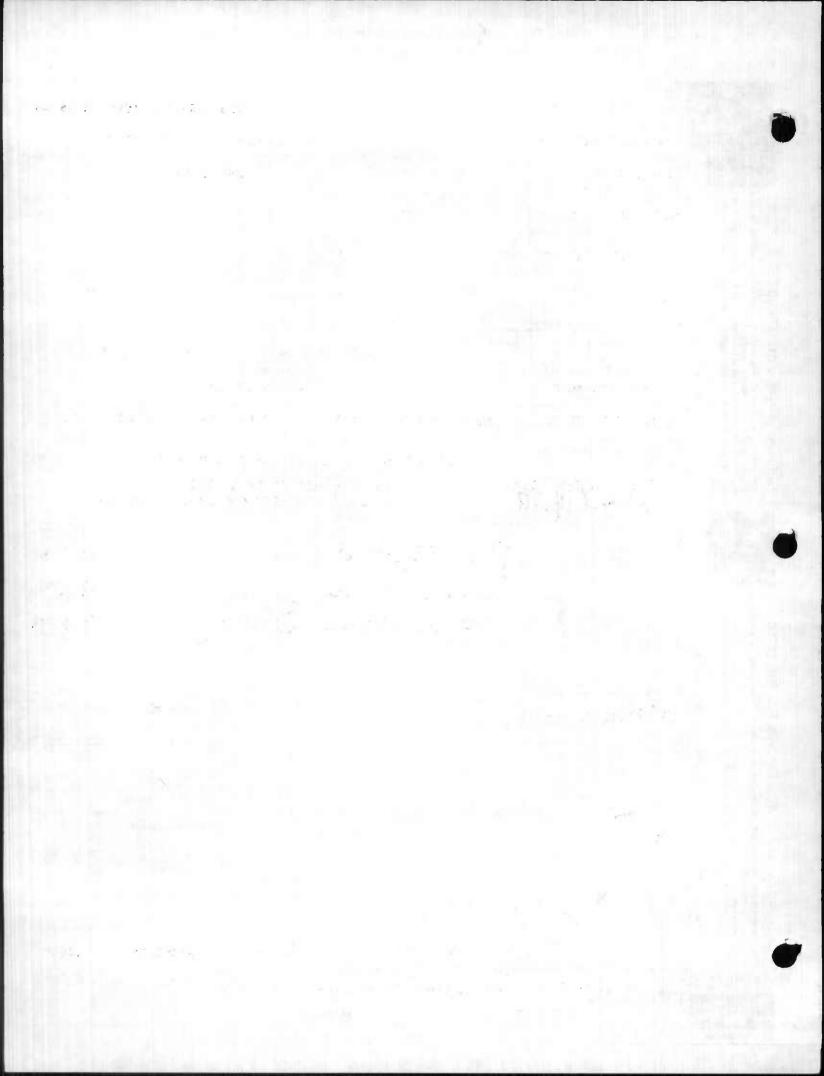
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician EVELYN** В. MYERLY FEBRUARY 18, 1999 3:05 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner SACRED HEART HOSPITAL ALLEGANY CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 XF Months Deys Hours Min Yrs. 92 AUG 13 1906 PA 215-26-9419 **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumstic event, the Medical Example must be not if an once. 10b. County MARYLAND ALLEGANY LAVALE 1 Yes 2 No Directo 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1213 WEST BRADDOCK ROAD 21502 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: WHITE Specify: þ 3 ♥ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) JEANNINE'S BOUTIQUE SALESPERSON 12 + 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be GEORGE BARRAGER CLARA LUTEMAN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) JEANNINE M. CLARK DAUGHTER 1247 WEST BRADDOCK ROAD LAVALE MARYLAND 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) INDIAN MOUND CEMETERY FEB 22 1999 ROMNEY WEST VIRGINIA 22. Name and Address of Fecility
MERRITT-ADAMS FUNERAL HOME grull 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner attending physician and for use as the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequenca of) that the death certificate be execu Box 68760. Due to (or es e consequence of) 23b. Did tobacco usa contributa to the cause of death? ed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 200No 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Were autopsy findings evellable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed certificate has b lirector, page 2 s 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Inpatient 1 Yes No 10 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Yes 2 No death. d in by the fa 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homloide To the Hospital within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the ceuse(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and 29a. Certifier Medical completely eminer: On the besis of examinetion and/or Investigetion, in my opinion, death occurred at the time, date end pleca, end due to the cause(s) and manner steted. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of contilion 29c. License number **FEBRUARY** 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Setond 902 Welik Hobert 32. Registrar's Signeture 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar

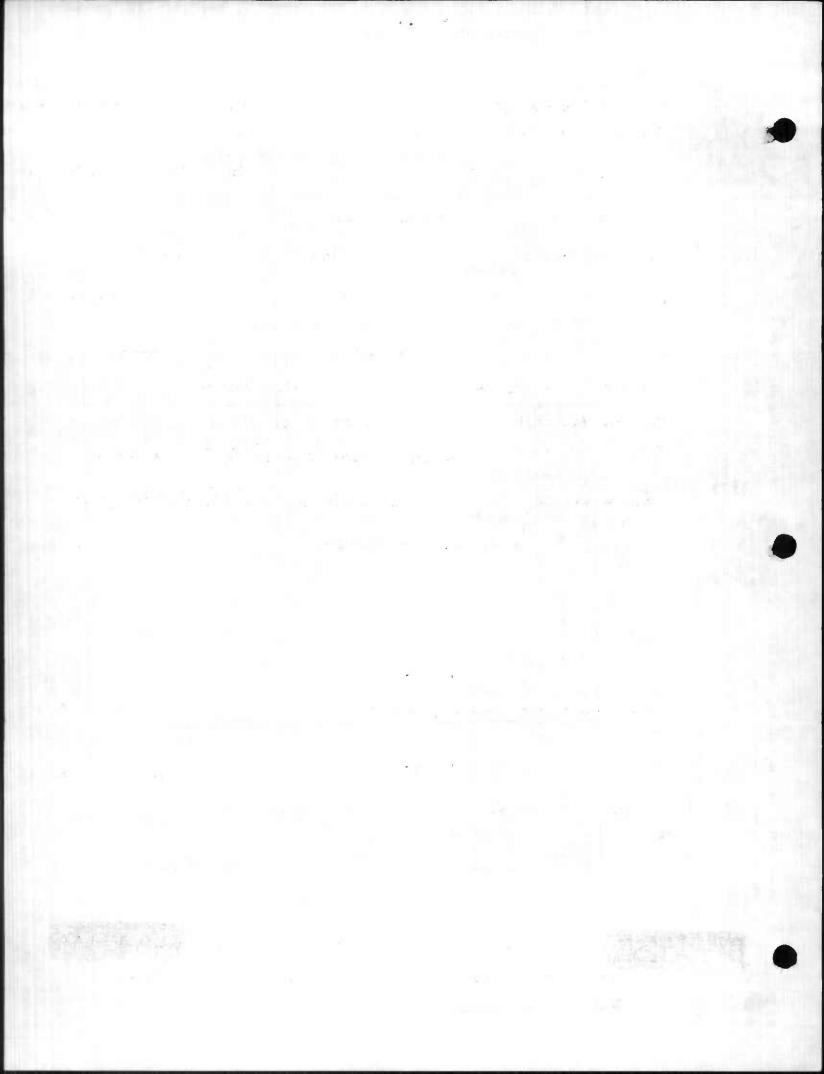
FEB 22



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Tima of Death HEBRUARY 28, **Physician** 1999 11:20 AN Mary Lellon Monaghan /Medical 4a Facility Nama (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore Towson 8. Data of Birth (Month, Dey, Year) July 7, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign
Country) **Funeral** 1□M 2X F Months Days Hours North Carolina 84 Yrs. 579-18-2105 Director Usual Rasidance of Decedent 10d. Insida City Limits 10a State 10b. County 10c. City. Town or Location 1 Yas 2 No NC Sampson Director Newton Grove 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8 the Medical Examiner must be Herns 23a 2900 Eldridge Road U.S.A. 28366 Funeral 12. Was Dacedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14 Bace - American Indian Bleck, White, atc. 1 ☐ Nevar Married 2 ☐ Married 6 Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify: White þ 3 N Widowed 4 □ Divorced Completed 15. Decadant's Education (Specify only highast grada complated) 16a, Dacedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middle, Last) should be Mental h and Mental William James Boyette Anna Holder 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is Dixie B. Nacincik 2815 Garrett Rd., White Hall, MD 21161 Saltimore. 20a. Mathod of Disposition 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata March 10 1 Burial 2 Cramation 3 Ramoval from Stata ò Arlington, VA Arlington National Cemetery 1999 4 □ Donation 5 □ Othar (Specify) 22. Nama and Addrass of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA Breit 17349 231 Part1. Enter the disease, or complications the shock, or heart failure. List only one complications Approximate Interval Batween Onsat and Death d the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, **Physician** ASPIRATION PNEUMONIA 13 DAYS Immediata Causa (Final disaese or condition resulting in daath) /Medical Examiner Due to (or es e consequence of): Examiner physician and the buriel-tran Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of): certificete be exec Box 68760 Physician/Medical Dua fo (or as a consaquance of): 98 950 for 23b. Did tobacco uas contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. the the 1 ☐ Yes 2 ☐ No 3 ☐ Probably Munknown CHRONIC OBSTRUCTION PULMONARY DISEASE signed I P 24b. Wara autopsy findings available prior to complation of ceusa of deeth? 24a. Was an autopsy performed? Completed hes 1 Yes No 1 Yas 2 No certificate after death.

Director: After this certific funerel director, Be 25. Wes casa refarred to medicel examinar? 26. Place of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 25 No P 1 Impatiant 2 ER/Outpatiant 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: Natural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be datarmined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida in 24 hous. Hospital Certifying Phyeiclan: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the causa(s) and mannar es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mannar stated. 29a. Cartifiar edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and fitia of certifian 29c. Licensa number millia m.O D41410 0 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print) JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MD 21204 32. A strai's Signatura State 1999 Sporks Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 13, 1999 5:30 PM Virginia Josey Newsome /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 2300 Ross Road Silver Spring Montgomery If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) June 12, 1934 9. Birthpiece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2\ F Months Deys Illinois 64 Yrs. 338 28 8079 Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 14 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 2300 Ross Road 20910 United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Merital Status permit Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examina 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) University Elementary/Secondary (0-12) Coilege (1-4or 5+) Professor District of Columbia 18 Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Eva Alston Leon Josey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2300 Ross Road, Silver Spring, MD John Newsome / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 2/22/99 Beltsville, MD 4 □ Donation , 5 □ Other (Specify) 21. Signature of Funeral Service Liceose 22. Name and Address of Facility McGuire Funeral Service, Inc. any in 7400 Georgia Ave. N.W., Washington, D.C. 20012 wen e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death tati the de Physician Immediate Cause (Fina disease or condition resulting in direth) /Medical Cardiomyopathy Examiner Due to (or as a consequence of): Examine Diabetes Mellitus physician and the burlai-fransi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhibated events resulting in death) Lest Due to (or as a consequence of): 8 Physician/Medical Due to (or as a consequence of): 8 995 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 6 signed to þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death?

page 2 788 certificate 200

after desi Director: A 24 hos. Funeral Dir filled iv Hospital To the 1 Within 2 To the 9

Box 68760 P.O. Division of Vital Records. Attending

Completed 25. Was case referred to medical examiner? Be 10 27. Magner of Death 1 ENatural

Certification:

Medical

Registrar

and address of person who completed cause of death (Item 23a) (Type, Print) William Frederick, M.D. 31. Date filed (Month, Day, Year)

1□ Yes 2 No

2 Accident

3 Suicide

4 Homicide

29a: Certifier

dow)

5 ☐ Pending

FEB 2 2 1999

investigation

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

28b. Time of

Other: 4 Nursing Home 5 \$\overline{\text{Nesidence}}\$ Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

106 Irving Street, #304 N.W. Washington, D.C.

281. Location (Street and Number or Flural Floute Number, City or Town, State)

1 Yes 2X No

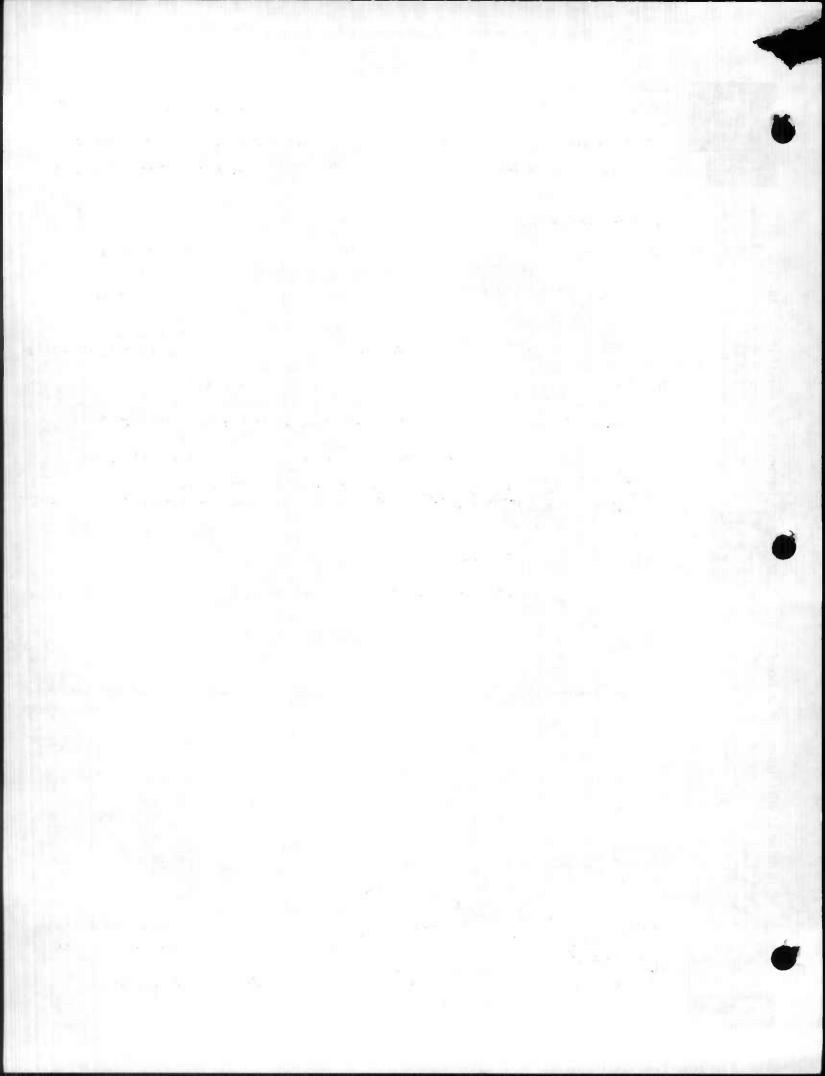
1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my infolledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. Ligense number

> -4502February 19, 1999

oaks

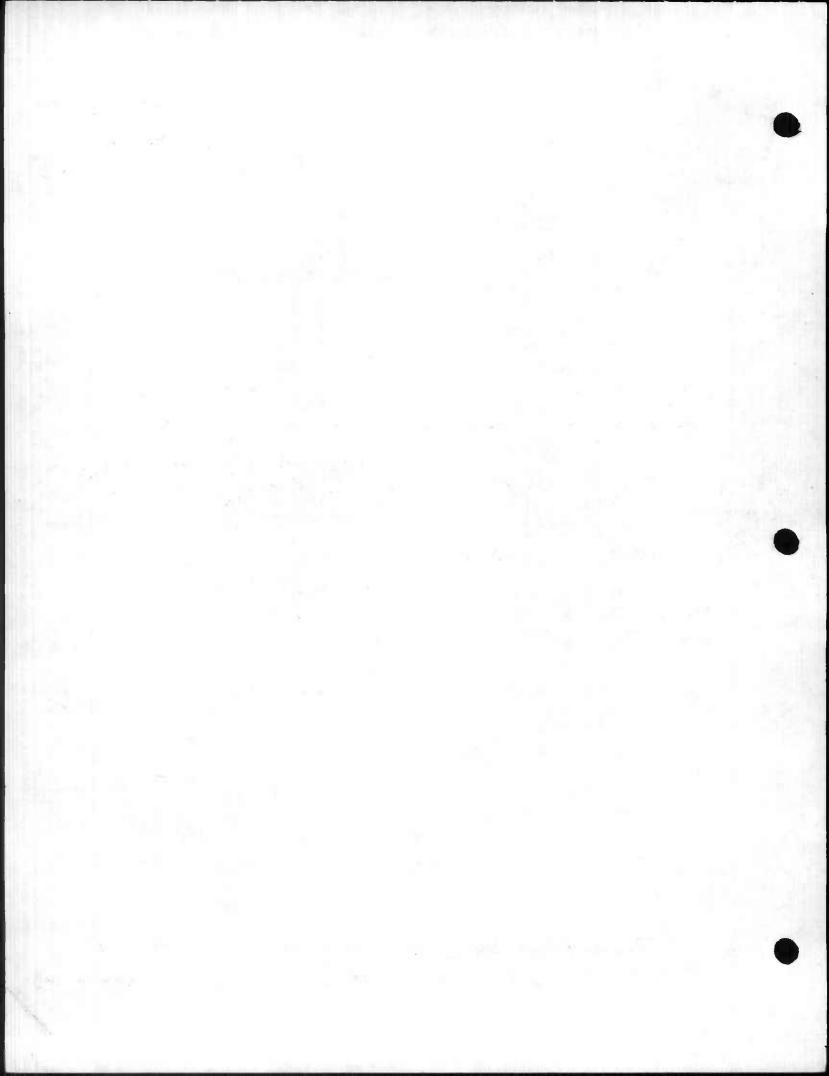
DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 9 9 0 7 2 8 0

			Cei	rtificate of	Death		Reg. No.	01200
	1. Decedent's Neme (First, Middle, La	ist)				2. Date of Dea		3. Time of Death
Physician (Madical	Eva Nalevanko					Month	23 199	9 5:55 Pm
/Medical Examiner	4a Fecility Neme (If not institution, given	re street and number)			4b. City, Town,	or Location of Death	4c. County	of Death
CAUTITION	Holy Cross Hos	nital			Silve.	r Spring	Mon	tgomery
	5. Social Security Number 6. S		s. last birthday)	If Under 1 Year	r If Undar 24 H	Irs. 8. Dete of Birt		0
Funeral Director		1□M 2☑F 81	Yrs.	Montha Days	Hours M	in. (Month, Day March 6	y, Year)	9. Birthplace (State or Foreign Country) Pennsylvania
2	Usual Residence of Decedent					piaren o	, 1)1/	rennsyrvania
A ST	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
Man Man	PA Fayett	ie e	Dunh	oar				1 ☐ Yes 2 ☒ No
vith the Ma or 28a-f be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
		Road		1.54	431		USA	Δ
ther death v thems 23s siner.mast	11. Marital Status	12. Was Decedent Ever in	U,S. 13. 1	Was Decedent of	Hispanic Origin?	(Specify Yaa or No-	14. Race	- Amarican Indian,
O star	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yas, specify Cul		erto Rican, etc.)	Bleck	k, White, etc.
DX 68.0	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
Maryland 21215-0020 td 2 should be filed within 72 hours at this and Martai Hyglere. T'ils marked other than "natures", or traumatic event, the Medical Exam To Re Completed by 8	15. Decedent's E		16a. Deced	dent's Usuel Occu	pation		16b. Kind of Bu	siness/Industry
I 21215-0 led within 72 ho yglens. In the Instur It, the Medical.	(Specify only highest grant Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retin	eduring most of v ed)	vorking		
Para di ma	8	College (1-4or 5+)	Ov	mer			Dairy 1	Farm
Be Cothe	17. Father's Nama (First, Middla, Last)			18. Mother's N	lame (First, Middle,		
Tal adding a					100	Mary Skri	D	
T. T.	19a. Informant's Name/Relationship (Type, Print)	19b. Meilir	na Address (Stree		Rural Route Number		State, Zip Code)
and 2 path a n 27 is ser trau	Dorothy N. Vrobel	(daughter)				Woodbridg		22193
9 TT 16	20a. Method of Disposition		Plece of Dispo	sition (Name of		Dete		City or Town, Stete
Baltimore, permit. Pages 1 an Department of Heat Important: if then 2 any injury or other anse.	1 Burial 2 Cremetion 3 5	Removel from State	•	matory or other pla		10/07/00	**	7.4
Saltin omit. Pa Nepartmar mportant ny Injury INSE.	4 Donetion 5 Other (Special 21, Signal of Huneral Service Lice					2/27/99		wn, PA ns Funeral
Ball Separt mport my inj	21. Signal of Pulleral Service Lice	000		ome, Inc.		niversity		
	mohen	Love	Si	ilver Sp	ring, MD	20901		
	23a. Pert1. Enter the disease, or com shock, or heart feilure. List only	plications that caused the decome cause on each line.	ath. Do not ent	er the mode of dy	ring, such as card	liec or respiretory er	rest,	Approximete Intervel Between
Physician		V						Onsat and Death
/Medical	Immediate Cause (Final disease or condition	Cardiopulm	nonary A	Arrest				1 week
Examiner	resulting in deeth)	Due to	(or as a consec	quence ol):				
7 H		Ruptured T	horaic	Aortic A	Aneurysm			
(58 / 50), riflicate be axecuted ing physician and as the burial-transit	Sequentially list conditions, if eny, leading to immediate	Due to	(or es e conseq	quence of):				
Ex maria	if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury							
(68/60, rdificate be assour ng physician and sat the burial-trar	that initiated events resulting in death) Last	C. Due to (or es a conseq	uence of):				
	resulting in coauti) Last							
		d						
deat deat	Pert II. Other significant conditions of	contributing to death but not re	sulting in the u	nderlving cause g	iven in Pert I.	23b. Did 1	obacco use con	otribute to the cause of death?
at the death ce d by the attendieteched for us.							Yee 2 No	3 Probably 4 Unknown
S, the set the bedeed by BV						_		
RECORDS, P.O. BOX he law requires that the death ce has been signed by the attendi age 2 should be detached for use ombleted by Physician/						24a. Was	an autopsy	24b. Were autopsy tindings
The law requirements the law requirements before the page 2 should Completed						perlo	rmed?	available prior to completion of cause of death?
The law are has by page 2 s							de	
Coate						101	res 25No	1 ☐ Yas 2 ☐ No
Of VICE Physician: ribis certific inal director.	25. Wes casa referred to medical examiner?	Hospitel:		To		Death (Check only o	ne)	
hyak this o		Inpatient 2L	☐ ER/Outpatier	IL SEL DON		Home 5 Resid		
UNISION OF VITAL for Attending Physician: The after death. Director: After this certificate in by the funaral director, profile attification: To Be Coertification: To Be Coertification: To Be Coertification: To Be Co	27. Manner of Death 1 ☑Naturel 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W		28d. Describe I	now injury occurr	ed De
Attending at death. ctor: Afte by the funding the fun	2 Accident investigation 3 Suicide 6 Could not b			M 1[Yes 2□No			Harris March
DIVISION of the office of the	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str	reet, factory, office		28f. Location (S City or Tox		er or Rural Route Number,
O de la								
n 24 hound n 24 hound n 24 hound ne Funer pletely fill bedical	29a. Certifier 1 Certifying Ph	ysician: To the best of my kn niner: On the basis of examin	owledge, death	occurred at the t	time, date and pla	ice, and due to the	cause(s) and ma	nner es stated.
		and manner stated.				Addition of the thine,	oute end place, i	due to the cause(s)
To the Total	29b. Signeture and title of certifier	, (,			nse number		29d. Date signed	(Month, Day, Year)
15	2 aug Ro	het star	MI	03	8418		2/24	1977
	30. Name end eddress of person who	completed cause of death (Ite	om 23a) (Type,	Print)			1	
	Laurence	Robert S	THUIN	1 2730	UNIVERS	Ity BUND	. West	Whaton, m)
State	31. Data filed (Month, Day, Year)	32. Registrar's Sign	nature			1		
Registrar	FEB 25 1999	Serva	19	low V.	,			

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

			Cer	rtificate of	Death	F	Reg. No.	U	1581
Physician	1. Decedent's Name (First, Middle, La	st)				2. Dete of Dea	th Day	Year	3. Time of Death
/Medical	Dorothy	Mar	ie	Nutt		Februar	y 20 1	999	1357
Examiner	4a. Facility Name (If not institution, giv		cnital		4b. City, Town, or Chester		4c. County Kent		
	The Kent and Que		yrs. lest birthday)	If Under 1 Year					
uneral rector		DA WIVE	68 Yrs.	Months Days		(Month, De)	11, 1930	Count	ace (State or Foreig try) and
8 ==	10e. Stete 10b. County	10c	City, Town or Lo	cation				10	Od. Inside City Limit
to to	Maryland Ouee	n Anne's	Maryde	1					1 ☐ Yes 2 ☐ N
Example Total Director	10e. Street end Number		, , ,	10f. Zip Code			10g. Citizen of W	/hat Coun	try?
a le	1710 Busic Church	Road		21649)		United S	State	S
Funeral Director		12. Was Decedent Ever in Armed Forces?			Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)		a - America k, White, e	
1 by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I□Yes 25 No	Specify:		Specify.	Whi	te
Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	lent's Usual Occup kind of work done	pation during most of wo d)	rking	16b. Kind of Bu	siness/Ind	ustry
m Medical Examiner in impleted by Funel	Elementery/Secondary (0-12)	College (1-4or 5+)			od)				
			Homema	ker	18 Mother's Nar	ne (First, Middle,	Domestic	Own	/Home
To Be								*/	
F	19a. informant's Name/Relationship (Гуре, Print)	19b. Mailin	g Address (Street	LOTA and Number or R	May Garr		State. Zio	Code)
r tra	Sharon Anderson	Daughter			rive, Fa			,	,
	20a. Method of Disposition	20	b. Place of Dispos	sition (Name of natory or other pla		Date	20c. Location -	City or Tov	wn, Stete Maryland
any injury or other tr	1 Suriel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	-		ry - Feb	ruary 25	lemplevi	llle,	Maryland
y Injury	21. Signature of Funeral Service Licen		22	Name and Addre	ess of Facility Ifenbein &	Luary 25	, 1000		
any le	1 Brick Q	Hellen	hein it	ellows, He	Litenbein &	Newnam Fur	neral Home	, P.A	
	23a. Part1. Enter the disease, or company shock, or heert failure. List only	olicetions that oaused the c	death. Do not ente	or the mode of dyi	Street, M	or respiratory er	Mary Land		Approximete
an	Shock, or neer failure. List only	one ceuse on each line.						1	Interval Between Onset and Death
al	Immediate Cause (Final disease or condition resulting in death)	Cave	dio Rapi	vatory.	Arrest				lowing.
er	resulting in death)	Due t	to (or es a consequ						
- Jule	11/27/11	D. CH	(+)						3 hours
Examiner	Sequentially list conditions, if any, leeding to immediate	Due t	to (or as a consequ		1 00		10 "		
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	6. ASC	LVD3 F	AND ACU	cte ou Chi	onic Re	nal failu	ve	
Medicai Examir	that Initieted events resulting in death) Last	Due to	o (or es a consequ	ience of);				į	
		d							
Cia	Post II. Other classificant and distance		and the second						
Physician/	Pert II. Other significant conditions co								the cause of death ably 4 - Unknow
by P	DIN TypeII, H-	TN Cardio	my o part	ley Hort	ic) touos	is we	es 2 No	3 Probe	abiy 4 Dilkilon
Completed by Pl	HEMI , HE CAE							con	re autopsy findings liable prior to appletion of cause eath?
Com						1□ Y	es 212No	1 🗆	Yes 2□ No
o Be C	25. Was case referred to medical				26. Place of Dea	ith (Check only or			
10	examiner? 1 Yes 2 X No	Hospital: 1 Inpatient 2	2 ER/Outpatient	3 DOA Oth	ner: 4 Nursing H	ome 5 Resid	ence 6 Othe	r (Specify)
	27. Menner of Death 1 ☑ Natural 5 ☐ Pending	28e. Dete of Injury (Month, Day Year	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe h	ow Injury occurre	∌d	
Certification:	2 Accident investigation				Yes 2 □ No				
Medical Certifi	3 Suicide 6 Could not be determined	28e. Placa of Injury - A building, etc. (Spe	vt home, farm, stre ecify)	et, factory, office		28f. Location (S City or Town		r or Rural	Route Number,
edicai Ce	29a. Certifier 12 Certifying Ph	valcian: To the best of my liner: On the basis of exam	knowledge, death	occurred at the tir	ne, date and place	, and due to the c	ause(s) and mer	ner as sta	ated.
8	one)	and manner stated.	Illiation and/or live	estigation, in my d	pinion, death occu	rred at the time, d	ate and place, e	na que to	tne cause(s)
×	29b. Signature end title of certifier	2		29c. Licens		2	9d. Date signed		ay, Year)
	had some	KODIS		D50	796		2/20/2	16	
0	30. Name and address of person who o			Print)	s. 11 1.				
0	100 Brown St. Ch			No. (2	Steddowdl	40	_		
State	31. Date filed (Month, Dey, Year)	32. Registrar's Si	gnature 4	dra 4	1,				

with the world the same

Box 68760 P.O. Division of Vital Records.

State Registrar

MANGARIAN 31. Data filad (Month, Day, Yaar)

FEB 26

29b. Signature end titla of certifiar

30. Name and eddress of person who complated causa of daath (Item 23a) (Type, Print) D. Weres

1999

(m 32. Ragistrar's Signatura

111 Penn Street, Baltimore, Maryland 21201 Backer

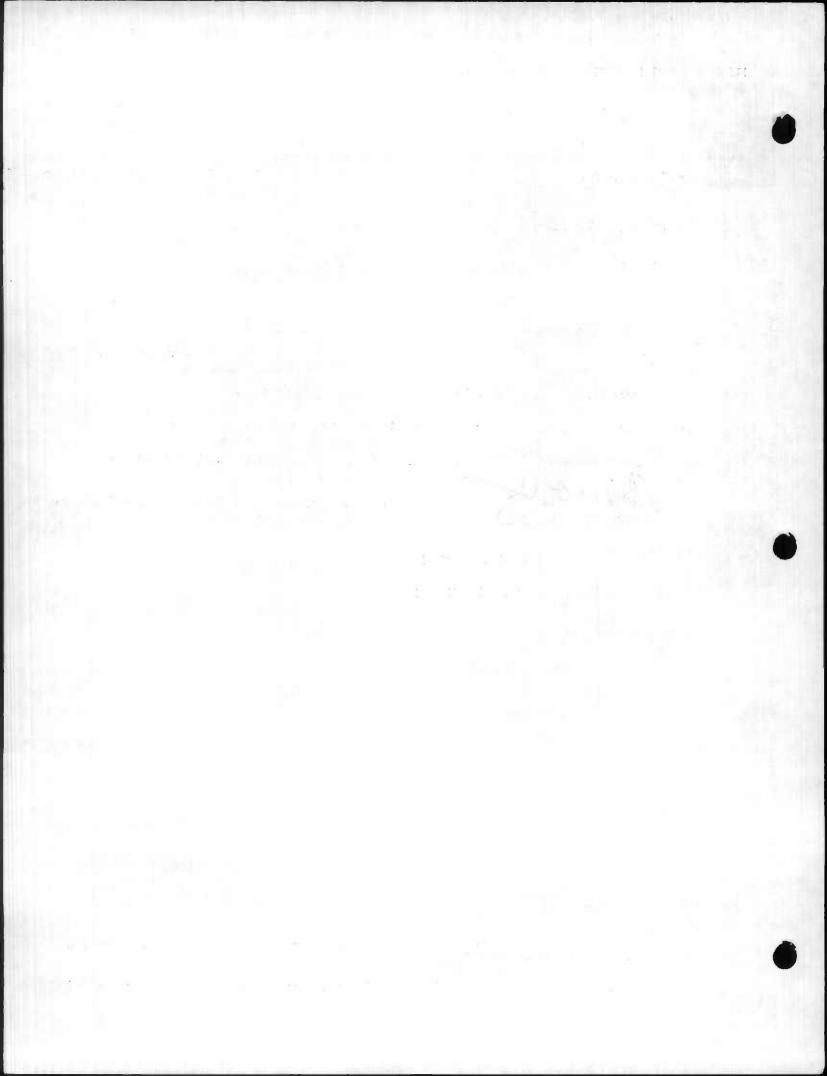
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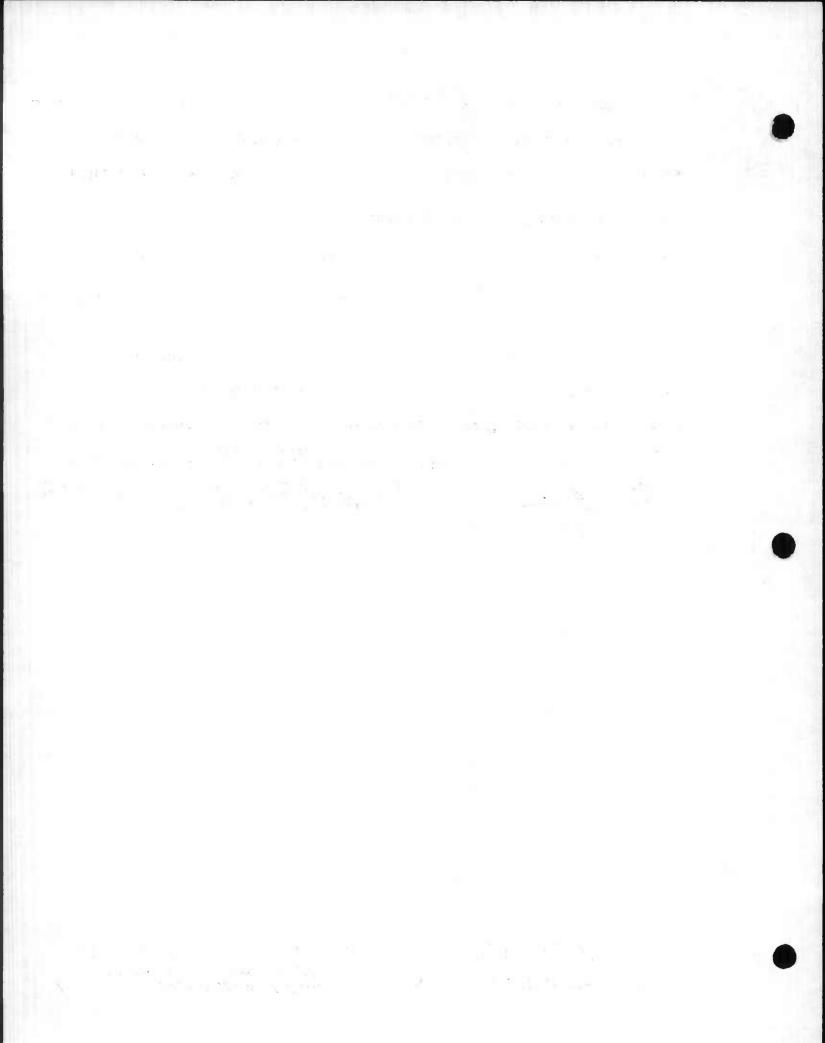
29d. Dete signed (Month, Day, Year)

FEBRUARY 24,1999

DHMH 16 Rev 6/95



Dhood		1. Decedent's Neme (First, Middle, Last)	Loomes		tificate				2. Dete of De	Davi		3. Time of Death
Physici /Medic			'CONNO	R							9 Šear	6:36 Pi
Examir	ner	4e. Facility Neme (If not institution, give street end number NATIONAL NAVAL MEDICAL		R			BET	HESD		MOI	of Death NTGOME	RY
uneral irector		5. Sociel Security Number 579-38-7391 6. Sex 1 M 2 F 7. Age (In yrs. lest birthdey) 86 Yrs. 1 Deys					If Under 2 Hours	Min.	8. Dete of Bird (Month, De Nov 1	Year) 4, 1912	9. Birthpled Country Illi1	ce (State or Fore
28a-f show notified at	lor	Usuel Residence of Decedent 10e. Stete 10b. County Maryland Montgomery		Town or Lo							10d	. Inside City Lin
or 28a	irec	10e. Street and Number			10f. Zip	Code				10g. Citizen of \	What Country	7
23a c	rai	4949 Battery Lane #212			20	814				United	State	S
ral", or items 23a or 28a-f shov Examine Lmust be nothed at	by Funeral Director	11. Meritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Deceden Armed Forces 1 Yes, Give Yeer or Detes:	No	No			spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		14. Rece - American Indien, Bleck, White, etc. Specify: White	
natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or				cupation ne during most of working lired)			16b. Kind of B			
9		17. Fether's Neme (First, Middle, Last)		Teac	her		18. Mother	r's Neme		D.C. Pu Maiden Sumen		chools
Is marked other than	To Be	Anthony Dwyer							McHale		/	
E E		19e. Informent's Neme/Reletionship (Type, Print)		19b. Meillr	g Address	(Street a	and Numbe	r or Rura	Route Number	er, City or Town,	Stete, Zip C	ode)
Item 27 other tr		Margaret D. Carroll/Daught					lane i	212,	Bethe	sda, Ma		
ant: If the ury or off		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)	cerr	etery, crer	sition (Nem natory or ot n Nat:	her plec	March 1 Cem	n 1, eter	Dete 1999 y	20c. Location - Arlingto		
Important: If II any injury or o		21. Signature of Funeral Service Licensee	M00198	R2	Name and 557 W Sethes	Address isco	onsin Mary	rey I Aver land	Suneral nue 20814	Home/B -3501	ethesd Chas	a-Chevy
vsician ledical aminer	niner	Immediate Cause (Finel disease or condition resulting in death)	PNEUM Due to (or e		uenca of):						0	nset and Deat
sicien and burial-tran	cai Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events	uence of):									
attending physicien and for use es the burial-transit	중	resulting in deeth) Lest	Due to (or e	s e conseq	uence of):							
the atte	Physician/M	Pert II. Other significant conditions contributing to death	but not resulti	ng in the u	nderlying ca	use give	en in Pert I.		23b. Dld	obacco use co	ntribute to th	ne cause of de
200		1 Yes 2 No 3							3 Probal	bly 4 ☐ Unkr		
s been signed 2 should be de	Completed by								24e. Wes	en autopsy med?	avalia	autopsy tinding able prior to eletion of cause ath?
page 2	mo:								10	res 2 DNo	101	res 2□ No
is certificate director, pag	Be	25. Wes case referred to medical exeminer?					26. Plece	of Deeth	(Check only o	ne)		
w 10	2	1 ☐ Yes 2 ☑ No Hospitel: 1 ☑ Inpat		NOutpatier			4 LI NUI			dence 6 Oth	. , , , ,	
or: After the funer	Certification:	27. Manner of Deeth 1 Neturel 5 Pending investigation 2 Accident 5 Could not be	ey Year)	8b. Time of Injury	М		ret i? res 2 □ N	No		now injury occur		
To the Funeral Director: A completely filled in by the fu		4 Homicide determined 256. Piece or in building, e	tc. (Specify)						City or Tov			
To the Funeral Completely filled	edicai	29e. Certifier (Check only one) 11 Certifying Physictan: To the best on the b	of examinetion									
To the comple	Me	29b. Signature and title of certifier	ė.		29c.	License	number			29d. Dete signe	d (Month, Da	y, Year)
>		Delletas m	D			-005	2824			Feb 2	2,199	9
		30. Name and address of person who completed cause of JOHN M. MCCURLEY, LCDR,			Print)				VAL MET 20889-	ICAL CE	NTER	
		31. Dete filed (Month, Dey, Year)	trer's Signetur	Total Control								

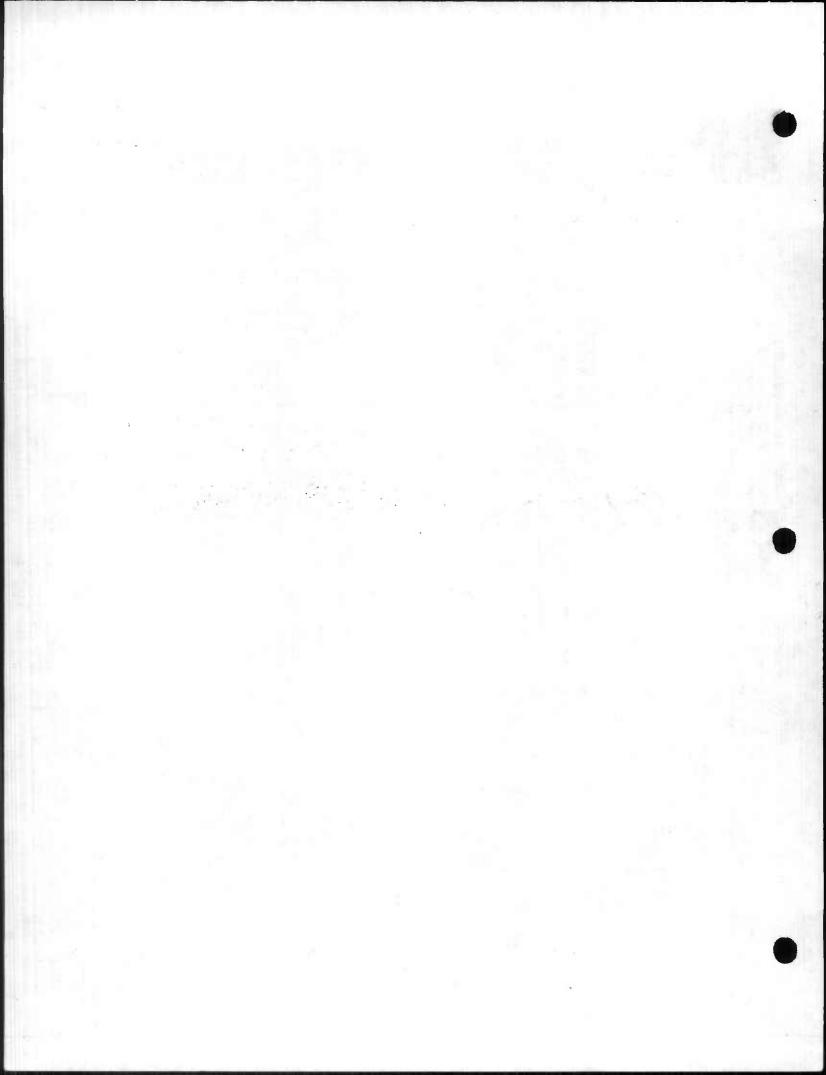


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dev Month **Physician** Marvin 0'De11 February 20, 1999 12:20 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1201 Allison Drive Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days 11 M 2□ F Hours Yrs. 230-31-9499 70 Director July 14, 1928 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1₺ Yes 2□No 28a-fa Directo Maryland | Montgomery Rockville 96 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? res 23a or 1201 Allison Drive 20851 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Black, White, etc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 8 1 Yas 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. filed within Elamantery/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be the ment of Health, and Mental Heart: If them 27 is marked oth jury or other traumatic even Be Truman O'Dell Mary Hurst 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Vera O'Dell/Wife 1201 Allison Drive, Rockville, Maryland 20851 20b. Piece of Disposition (Neme of cemetery, crematory or other placeFeb. 22, 1999 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any injury or Parklawn Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) Rockville, Maryland 22 Name end Address of Fecility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805 21. Signeture of Funeral Service Licenses M00198 e 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. nterval Betw Onset and Death **Physician** Immediete Ceusa (Final disease or condition resulting in death) /Medical Lung Cancer Examiner Due to (or es e consequence of): Examiner Ischemic Heart Disease sicien and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): physicien the buria Box 68760. Physician/Medical Due to (or es e consequence of): 98 080 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 6 1 No 3 Probably 4 Unknown signed t Cerebrovascular Disease, Gout, Hypertension Division of Vital Records. P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? Cardiac Arrhythymia page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only ona) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖫 Residence 6 ☐ Othar (Specify) Certification: To this funeral 27. Manner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Panding Investigation or Attanding within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital 1 X Certifying Physician: To the best of my knowledga, death occurred at the tima, data end place, end due to tha causa(s) and mannar es stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) end manner stated. edical 29a. Certifier (Check only 29b. Signeture end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) Douglas a Shumske D27301 February 20, 1999 15 30. Neme and address of person who complated cause of deeth (Item 23a) (Type, Print) Douglas R. Shumaker, M.D. 615 W. Montgomery Avenue, Rockville, Maryland 20850 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State FEB 23 1999 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Name (First, Middle, Last) **Physician** 23, 1999 DAISY MAY OWENS FEB. 12:26 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) MONTGOMERY If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (Stata or Foreign Country) **Funeral** 10 M 20 F Months Days Hours Min Yrs. Jamaica 84 228-78-7047 Director Usual Residence of Decedent the Maryland r 28a-f ahow a notified at 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits Montgomery XXVas 2 □ No MD Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Haath and Mantal Hygiena.
ant: If Item 27 ia marked other than "natural", or items 23e or inry or other traumatic event, the Medical Examinations in mall be in 9707 Forest Grove Drive 20910 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: 14. Raca - Amarlcan Indian. Was Decedent of Hispanic Orlgin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Nursing Assistant Medical yr. 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Evelyn Johnson John McNish 19a. Informant's Name/Relationship (Type, Print) (Grand- 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)20910Ann McCleary-Heron 9707 Forest Grove Dr., Silver Spring, MD Daughter) 20b. Place of Disposition (Name of cematery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Gate of Heaven Cem. 3/1/99 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signard of Funeral Service Licer® 22. Nama and Addrass of Facility
SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD name, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, the only one cause on each line. 23a. Part1. Entar thous Approximate Interval Between Onset and Death Physician /Medical Immediata Causa (Final disease or condition resulting in deeth) Cardiac Arrest Examiner Due to (or as a consequence of): Examiner Sepsis physician and the burial-transit law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated avants resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Perforated Viscus Physician/Medical Dua to (or as a consequence of): attending pl Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? the signed by the 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings avallable prior to complation of causa of death? should 24a. Was an autopsy Completed s certificate has t director, page 2 s The 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27, Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 BNatural 5 Pending investigation death. 1 Yes 2 No after death Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Mie of certifier 30. Name end address of person who completed cause of quath (flem 23a) (Type, Print) 1299 LAMbenton Drive Solver Spring MD 20902

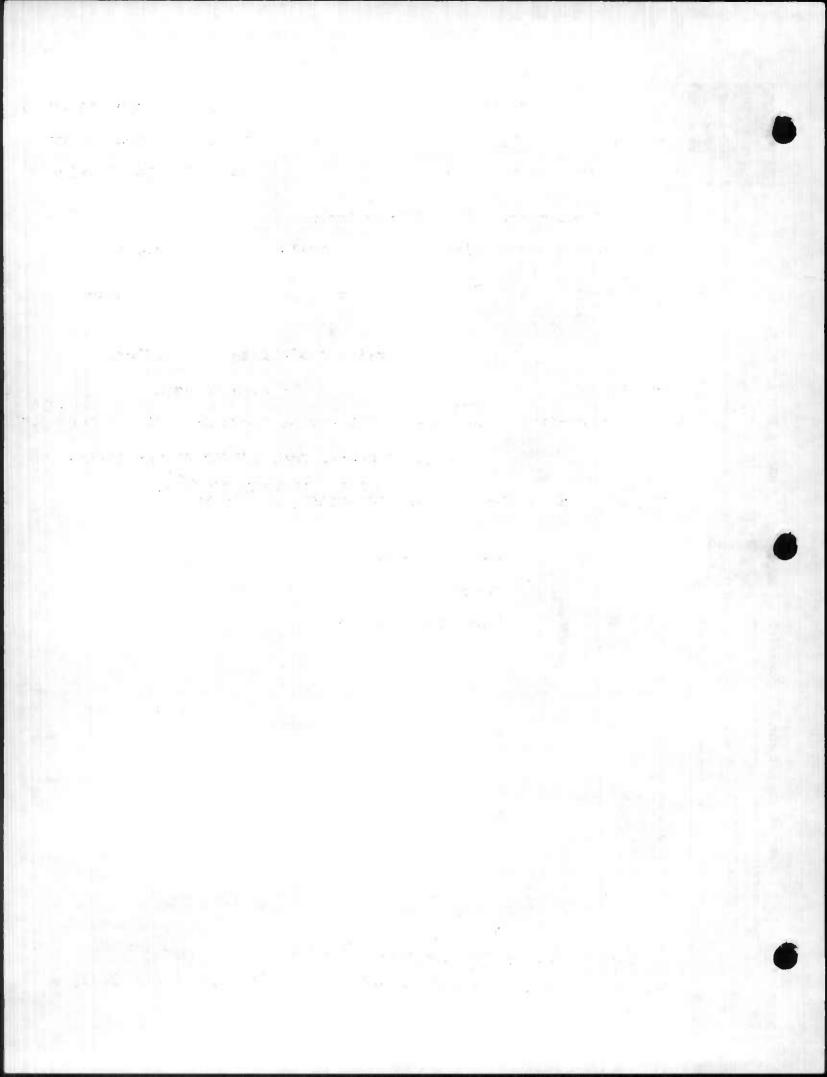
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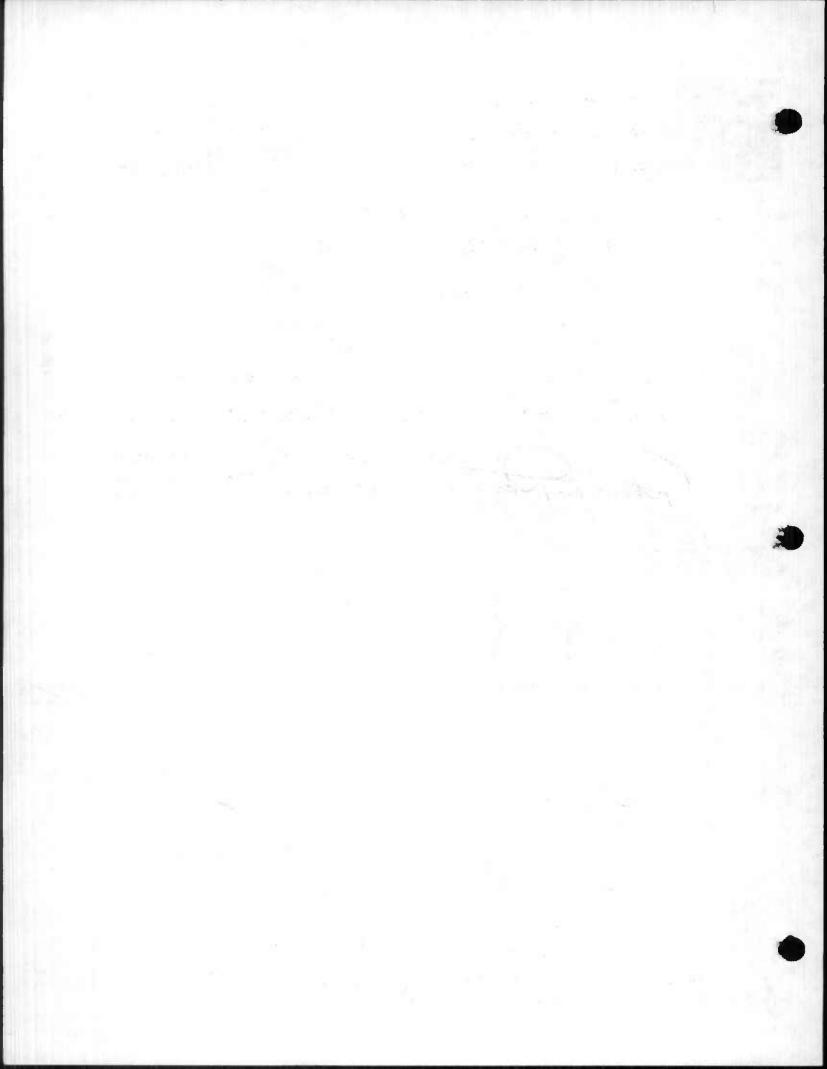
32. Registrar's Signature

mo



State of Maryland / Department of Health and Mental Hygiene 🔾 🔾

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death February 22, 1999 **Physician** Glenn Lee Putman Jr. 10:00 A.M. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16627 Sabillasville Rd. Sabillasville Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 2, 1921 5. Social Sacurity Number 9. Birthplaca (Stata or Foraign Country) Maryland 7. Aga (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 220-26-5416 77 Yrs Director Usual Residence of Dacedant 10a Stata 10h County 10c. City. Town or Location 10d. insida City Limits 28a-f show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Sabillasville 1 ☐ Yes 2 ☑ No Director Frederick 10e. Straet and Number 10f. Zip Coda 10g. Citizan of What Country? 21780 16627 Sabillasville Rd. U.S.A. death Funeral 12. Was Dacedent Ever in U,S. Armed Forcas?
1 (X/Yas 2 □ No If Yes, Giva Yaar or Datas: 42-46 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status Peges 1 and 2 should be filed within 72 hours efter near of Heelth and Mental Hygiene.
Int: If item 27 is marked other than "natural, or item inty or other traumatic event, the Medical Examine inty or other traumatic event, the Medical Examine. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White Completed by 3 Widowad 4 Divorced 16a. Dacedant's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacadant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Cans Mechanic 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Glenn Lee Putman Pearl Susan Harne 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) (Wife) Jane F. Putman 16627 Sabillasville Rd. Sabillasville. Md. 21780 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 B permit. Pege Department of important: If any injury or once. 5 Other (Specify Bethel Cemetery Feb. 25,1999 Cascade. Md. Signature of Funeral Service 22. Nama and Addrass of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarvai Batweer Onsat and Daath **Physiclan** /Medical Immediate Causa (Final disaasa or condition rasulting in deeth) Examiner Examiner The law requires that the death certificate be executed burial-trensit Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Ceusa (Disaasa or injury thet initiated avants rasulting in daath) Last Dua to (or as a consequence of) P.O. Box 68760, Physician/Medical the Dua to (or as a consequanca of): 80 USB ete has been signed by the atterpage 2 should be detached for Part II. Other significent conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death! 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Wera eutopsy findings evailabla prior to complation of cause of death? Completed 24a. Was an eutopsy performed? After this certificete has 1 Yes 2 No 1 □ Yes 2 □ No of Vital ai or Attending Physician: The setter death. Be 25. Was casa rafarrad to medical 26. Pieca of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital; 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Yas 2 → No filled in by the funeral 28a. Data of Injury (Month, Dey Year) 27. Manner of Daath 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how Injury occurred Division 1 Natural 5 Panding Invastigation 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be datarminad 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 Homleide To the Hospital within 24 hours e To the Funeral E Hospitai 29a. Certifia: Medical 1 Certifying Physicien: To tha best of my knowledge, daeth occurrad at tha tima, data and plece, and dua to tha ceuse(s) end menner es stated. 2 Medical Examilar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. Licansa number 29b. Signatura and titla of certifiar 29d. Data signad (Month, Dey, Year) M) 059027-L 23190 30. Nama and address of person who completed ceusa of daath (Itam 23a) (Type, Print) Waynesboro JEHANZEB QURESHI, 23 WALNUT ST. WAYNESBORO PA 17268 32. Programme Separature State Registrar



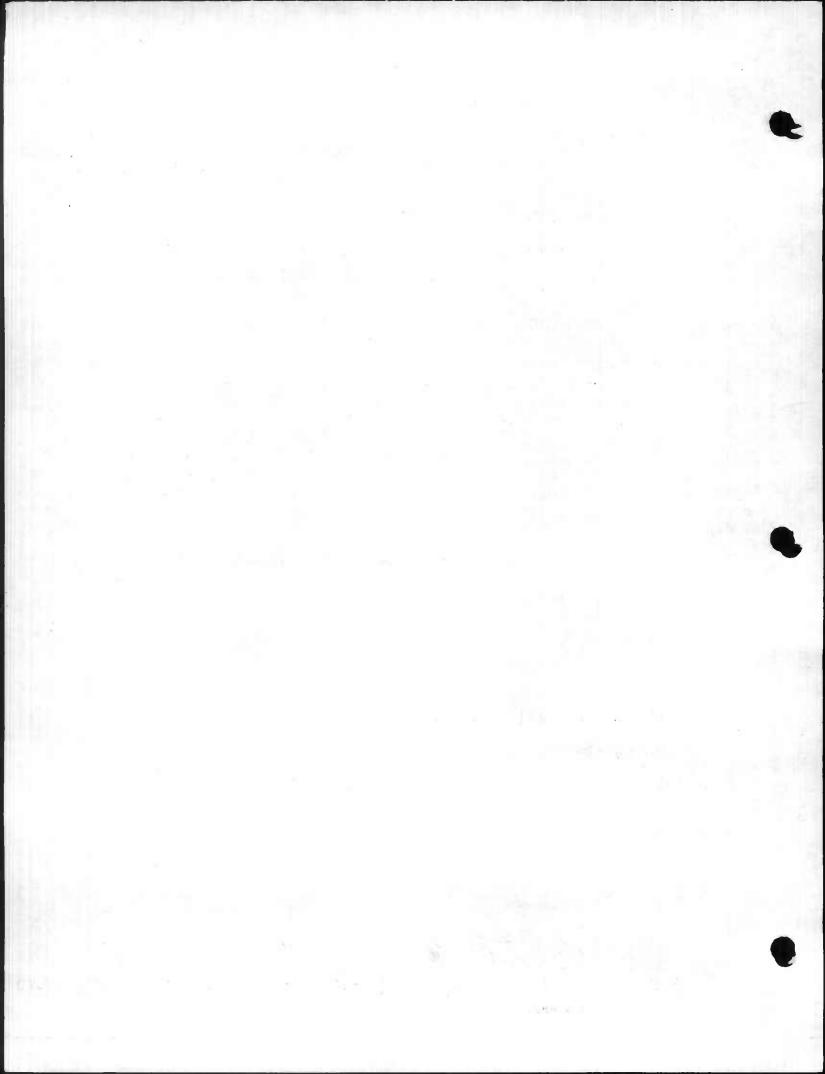
1. Decedent's Name (First, Middla, Last)

Certificate of Death

3. Time of Death

2. Date of Death

Month Physician Edward James PEARMAN, JR. 14:2 February /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deet Examiner Washington Washington County Hospital Hagerstown If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) July 4,1913 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Aga (In yrs. lest birthdey) If Under 1 Yaar **Funeral** Months Deys Hours 11 M 2□ F 85 Yrs. 214-03-6334 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 10917 Bower Avenue 21740 U.S.A. Funeral 11 Marital Status 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Naver Merried 2 Married 1 ☐ Yes 2 ☒ No tf Yes, Giva Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: p 3 Widowed 4 Divorced Yaer or Detas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Electric company 0 - 80 dispatcher pemit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: if item 27 is marked other tany injury or other traumatic aware. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Edward James Pearman, Sr. Carrie Bogaret 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10917 Bower Avenue, Hagerstown, Maryland 21740 Mrs. Hazel Pearman/wife 20b. Plece of Disposition (Name of cematery, cremetory or other place) Feb. 22,1999 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Rest Haven Cemetery Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Minnich Funeral Home 21. Signature of Funerel Service Licensee 22. Nama end Address of Facility me T. Spices 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Deeth **Physician** '/Medical Immediate Cause (Final diseese or condition resulting in deeth) 135 CK Examiner Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 ☐ Unknown 1 Yee 2 No Fibrillation by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? chronic Pulmonsu 1 ☐ Yes 2/2 No 1 ☐ Yes 2 ☐ No obstructive Division of Vital 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Naturel 5 Pending after deeth. 1 TYes 2 No investigation 2 Accident Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homloide 6 within 24 hours aft To the Funeral Dis completely filled in 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end mannar steted. 4 29b. Signetura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 0 ebrudry 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Williamspor er Ki 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 22 Registrar



State of Maryland / Department of Health and Mental Hygiene Q 07288

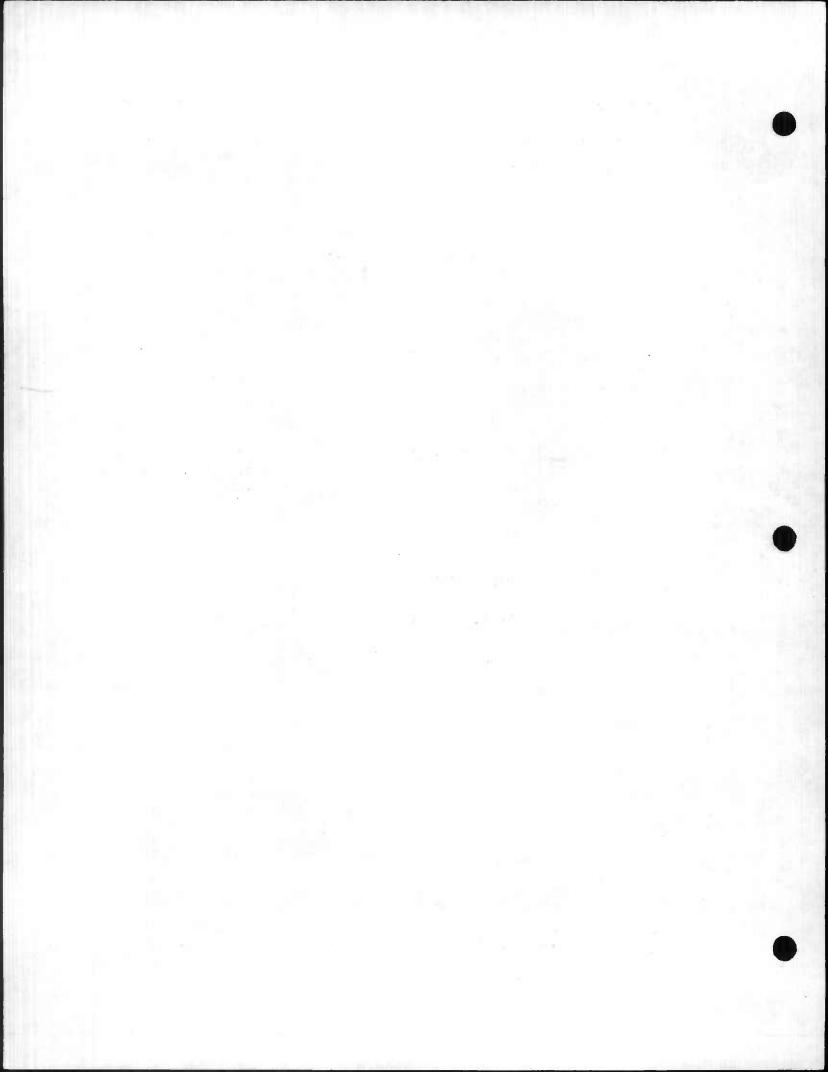
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Physid Med/		Betty Mae	PLANK				Februar		
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Funera Directo			Sex 7. Age (Ir	yrs. last birthdey) 69 Yrs.	If Under 1 Year Months Deys			v. Year)	Birthplece (State or Fore Country) Maryland
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28.0 0.001	Directo	10e. Street end Number	11180011		10f. Zip Code			10g. Citizen of Who	-
sth with	eral Di	11926 Iroquois A				21783		USA	
be filed within 72 hours after deeth with the Maryland stal Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examiner inset to notified at	by Funeral	11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Married 3 Widowed 4 ☐ Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No It Yes, Give Yeer or Detes:		Wes Decedent of t Yes, specify Cul t ☐ Yes 2 🖾 No	Hispenic Origin? (Span, Mexicen, Puer Specify:	Specify Yes or No to Ricen, etc.)	Bieck, Specify:	American Indian, White, etc. white
72 h	Completed	15. Decedent's E (Specify only highest gr		16e. Deced	ient's Usuel Occu	pation during most of wo	nrkina	16b. Kind ot Busin	ness/industry
E . E	nple	Elamentary/Secondary (0-12)	College (1-4or 5+)	life. L		during most of wo			
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2 should be i and Mental I is marked or aumetic eve	2	John Robinson				Cora	Mae unki	nown	
		19a, tntormant's Neme/Reletionship	(Type, Print)	19b. Meilin	ng Address (Stree	t and Number or R	urel Route Numb	er, City or Town, St.	ate, Zip Code)
7 - 7		Scott A. Plank -	son	1192	6 Iroque	ois Ave.,	Smithsh	ourg, Md.	21783
of Heelt Item 2 r other		20e. Method ot Disposition	2	Ob. Plece of Disportant Commetery, cren	sition (Neme of	ice)	Dete	20c. Location - Cit	ty or Town, Stete
		1 Burial 2 ☐ Cremetion 3 [4 ☐ Donetion 5 ☐ Other (Speci	THeiliovei Itolii Stete	Rest Have			-23-99	Hagerst	own,Maryland
		21. Signature of Funeral Service Lice			. Name end Addr			FUNERAL HO	
Departit. Departit Importa any Injk		1 James L.	Spices			The state of the s		stown, M	
Physician /Medica	_	23a. Part F. Enter the disease, or conshock, or haart tailure. List only Immediata Causa (Finel			er the mode of dy	ing, such es cerdie	c or respiretory e	rrest,	Approximete Intervel Between Onset and Death
Examine	_	disease or condition resulting in daeth)	e. Dro	wning					minutes
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pe jisi	투		b						
tricete be axecuted ig physician end as the burial-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying	Due	to (or es e conseq	uence ot):				
ysic he b	Medical	Cause (Diseese or Injury that Initiated events resulting in deeth) Lest	C. Due	to (or as a consequ	uence of):				1
ING P									
attendir I for use	an		d						
o dea	Sic	Pert II. Other significant conditions	contributing to death but no	ot resulting In the un	nderlying cause g	ven in Part I.	23b. Did	tobacco use contri	ibute to the cause of dea
met the de ned by the a detached i	y Physician/	Severe Alzheime	r's Disease				10	Yes 2☐XNo 3	☐ Probably 4☐ Unkn
6 8 6	ed by						24a. Wes	an autopsy	24b. Wara autopsy tinding availeble prior to
quires the							perio	illiou:	completion of cause of death?
s been signed s should be de	plet								
he law requires the e has been signed age 2 should be de	omplet						10	Ves 2KINo	1□Ves 2□No
the law requires ate has been sign page 2 should be	Completed	25. Was case retarred to medical	1			00 01 10		Yes 2 No	1 ☐ Yes 2 ☐ No
certifica rector,	Be C	25. Wes case raterred to medical examiner?	Hospital:	-W-22-0		hor	ath (Check only	one)	
certifica rector,	To Be	examiner? 1 🖄 Yes 2 □ No	1 L Inpatient	2 ER/Outpetien	I SLI DON	her: 4 Nursing i	ath (Check only of	one) dence 6 □Other	(Specify)
certifica rector,	To Be	examiner? 1 🖾 Yes 2 🗆 No 27. Menner of Deeth 1 🗆 Netural 5 🗆 Pending	28e. Dete of Injury (Month, Dey Ye	ar) 26b. Time of Injury	P 28c. Inju	her: 4 Nursing I	ath (Check only of Home 5 Resi	dence 6 Other	(Specify)
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State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** February 22, 1999 Marie A. Palmateer 12:00 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Chevy Chase Montgomery Manor Care - Chevy Chase If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Fore Country)
Oct. 12, 1902 Washington, DC 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 XF Yrs 578-56-7781 96 **Director** Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or Items 23s or 28s-1 show must be notified at 1 Yes 2X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 급 20906 15310 Beaverbrook Court, Apt. 2B USA Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) hours after 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify Specify: à 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Owner/Operator 12 Beverage Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is merised oth any Injury or offner traumetic even office. Be Lewis Paganus Paulina Gardella To 19b. Mailing Address (Street and Number or Rural Routs Number, City or Town, State, Zip Code) 19e, Informent's Neme/Relationship (Type, Print) 15310 Beaverbrook Ct, Apt. 2B, Silver Spring, MD 20906 Gordon Palmateer/Son 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Date cemetery, crematory or other place) 1 Removel from Stete Gate of Heaven Cemetery 2/26/99 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Frances J. Colli-Home Inc. 500 University Blvd., Collins Funeral 21. Signetu re of Funerel Service Licensee 20901 Silver Spring, MD evan Mono 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Cardio Pulmonary Arrest Examiner Oue to (or as a consequence of)
Hypertension Examiner physician and s the burial-transit that the death certificate be executed Due to (or es a consequence of): Sequentially fist conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Heart Failure Box 68760 Physician/Medical Due to (or es a consequence of): Arteriosclerotic Heart Disease signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 No Records, by The law requires 24b. Were eutopsy findings available prior to completion of causa of death? been si 24a. Wes an autopsy performed? Completed has page 2 2 🔯 No 1 ☐ Yes 2 ☐ No certificate 1 Yes Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Tyes 2 TX No 1 fnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and dua to the cause(s) end manner stated. 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) D17191 February 22, 1999 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) 20008 4607 Connecticut Avenue, N.W., Washington, DC Barrett L. Burka, M.D.

State Registrar 31. Dete filed (Month, Day, Year) FEB 2.5 1999 32. Registrar's Signeture

porks

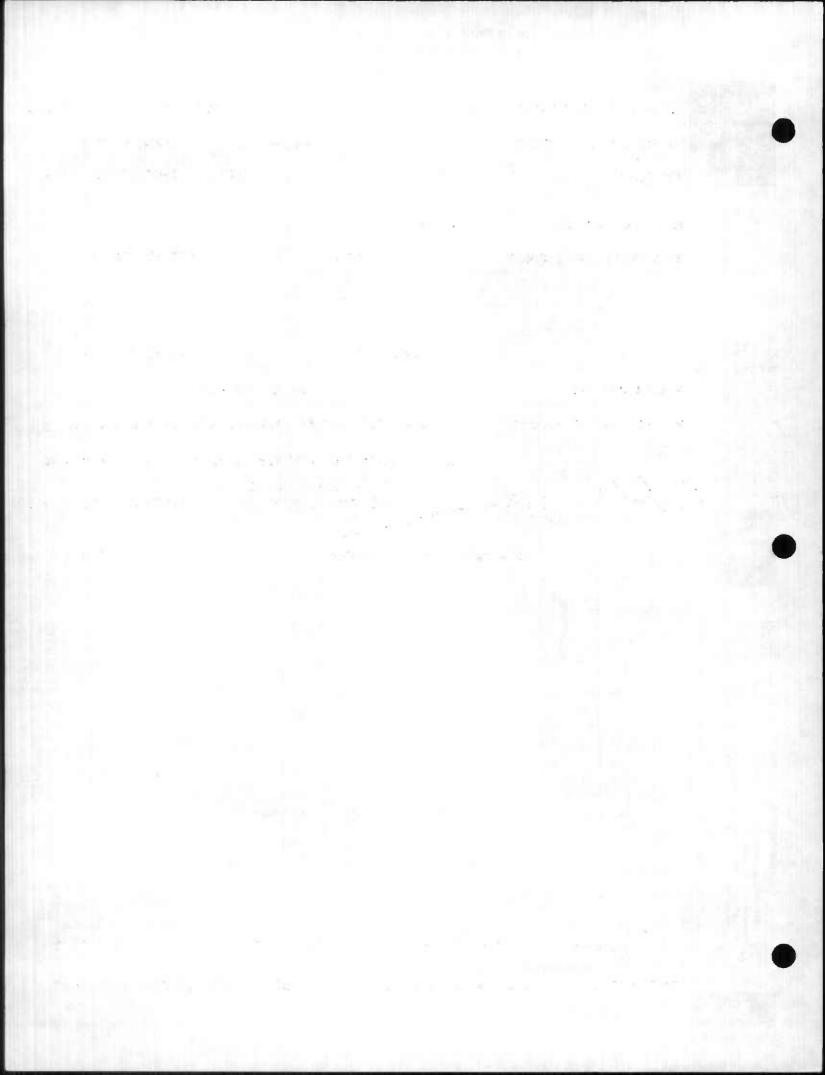


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No: 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month Yeer **Physician** FLORENCE HAGAR PAMELA PANDA FEBRUARY 18, 1999 9:50 A.M. /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) Examiner KAISER MEDICAL CENTER KENSINGTON MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdev) 8. Dete of Birth (Month, Dey, Year) **Funeral** Min Hours 1 M 2 NF Months Deys Dírector 48 JULY 29, 1950 SIERRA LEONE 229-35-2572 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10e Stete 10h Counts 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director MARYLAND HOWARD **JESSUP** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 8920 TWELVE SONS COURT 20794 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Biack, White, etc. parmit. Pages 1 and 2 should be filed within 72 hours effer Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or item in a finite or other traumatic event, the Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 Widowed 4 Divorced BLACK Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 CONCIERGE 0 HOTEL INDUSTRY 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) ARTHUR DOHERTY SARAH BENJAMIN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) MATILDA TAYLOR - COUSIN 8342 SAND CHERRY LANE, LAUREL, MARYLAND 20723 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete tXXBurial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) GEORGE WASHINGTON CEMETERY 2-27-99 ADELPHI, MARYLAND Signature of Fugeral Service Lice 22. Name end Address of Fecility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 idations that caused me death. On not enter the mode of dying, such as cerdiec or respiratory errest, no cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) METASTATIC GASTRIC CANCER 2 WEEKS Examiner Due to (or as e consequence of) Examiner physician and the burial-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): certificate be axecu Box 68760 Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): SB 980 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. detached signed by t d be detach 1 Yes 2 No 3 Probably 4 1 Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed has 1 Yes XXNO 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medical examiner? 26. Plece of Death (Check only one) To Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? funeral 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 X Neturel 5 ☐ Pending efter deeth. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide 0 • Funeral Hospital edical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examinar: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted. (Check only one) within 2 the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signetal and title of certifier 0 mo Markandle D46704 ahrah 10 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) MUTOMBO KANKONDE, M.D., KAISER PERMANENTE, KENSINGTON CENTER, KENSINGTON, MARYLAND 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture FEB 22 Sporks Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth

The law requires that the death certificate be executed buriel-tran and ettending physician the 88 the signed by peen certificate has Physician: this funaral within 24 hours efter death. To the Funeral Director: After or Attending filled in by Hospital

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Completed

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Certification:

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State

Registrar

P.O.

Division of Vital

3. Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 20, 1999 12:05PM MYUN K PARK /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not Institution, give street and number) Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) OCT. 5, 19 Birthplece (State or Foreign Country)
 KOREA 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days 1⊠M 2□ F Months Hours Min Yrs. 85 Director 225-27-7928 Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo SILVER SPRING MONTGOMERY MARYLAND 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code KOREA 1135 UNIVERSITY BLVD. WEST ROOM 809 20902 r death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examine 2008. 1 Never Merried 2K Married Specify: ASIAN 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) FARMER FARMING 12 18. Mother's Neme (First, Middle, Meiden Sumeme, 17. Father's Neme (First, Middle, Last) UNKNOWN UNKNOWN 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14211 GEORGIA AVE. APT 301 SILVER SPRING, MD 20906 SUNG PARK/SON 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/23/99 NORBECK MEMORIAL OLNEY, MD 22. Name and Address of Facility 21. Signeture of Funeral Servica Licansee HINES-RINALDI FUNERAL HOME, INC. Dimy 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Reiman Box 68760. Physician/Medical e consequence of): over 10 Hear

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

1 Yes 2 No

1 Yes 28 No

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 Could not be determined

27. Menner of Death

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how Injury occurred

28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 1 Yes 2 No N.A.M N.A. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N.A

N.A. 281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Xcertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.

26. Piece of Death (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dev. Year)

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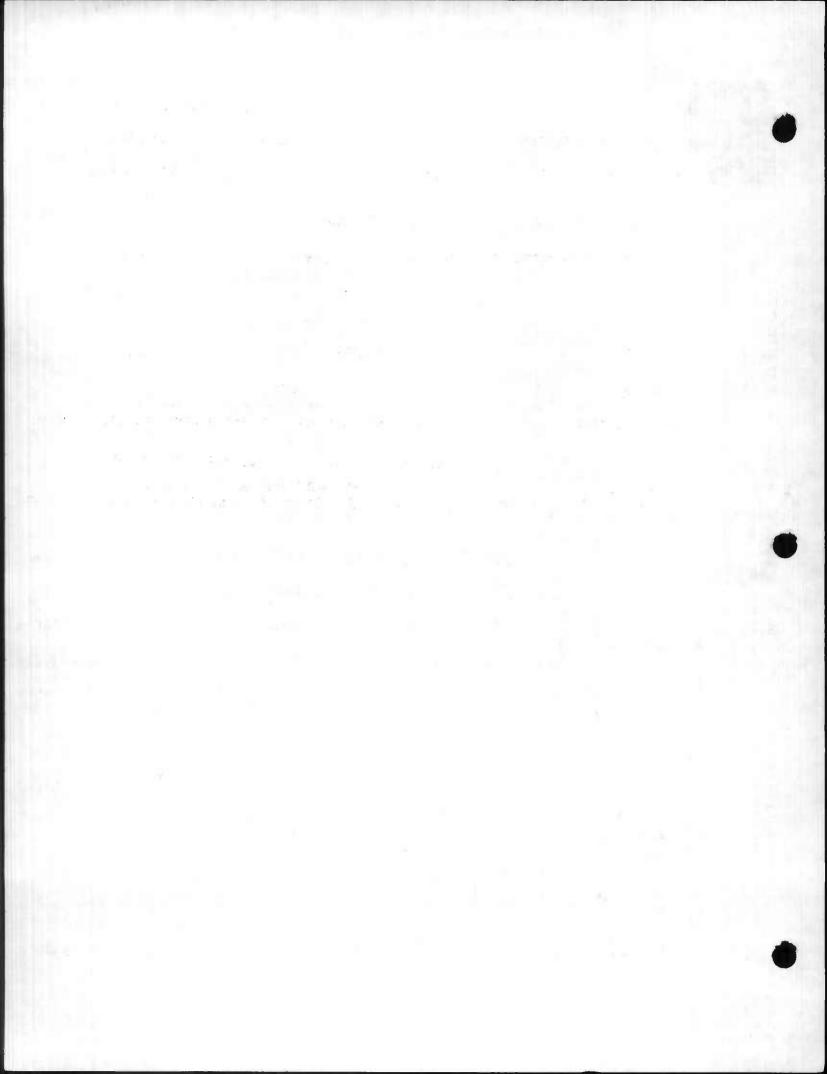
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

3000 Geor 31. Date filed (Month, Dey, Year) FEB 22 1999

32. Registrar's Signeture

Avenue

20



Physician /Medical Examiner physician and tha burial-trensit The law requires that the death cartificeta be executed P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

Directo

Funeral

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Hygiene.

Pages 1 and 2 should be 1 nent of Haalth and Mentel

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permit. Page Depertment of important: If ony injury or

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Baltimore, Maryland 21215-0020

Examiner ettending pl signed by the is certificate hes t i director, pega 2 s Hospital or Attending Physician:
 24 hours after daath.
 Funeral Director: After this certifica funeral

Physician/Medical by Completed Be Certification: To

edical

To the Hosp within 24 hor To the Fune complately fi 10 (13)

State Registrar

25. Was cese refarred to medice! axaminar? 1 Yee 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Netural 2 Accident 5 Pending 1 TYes 2 No investigation 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

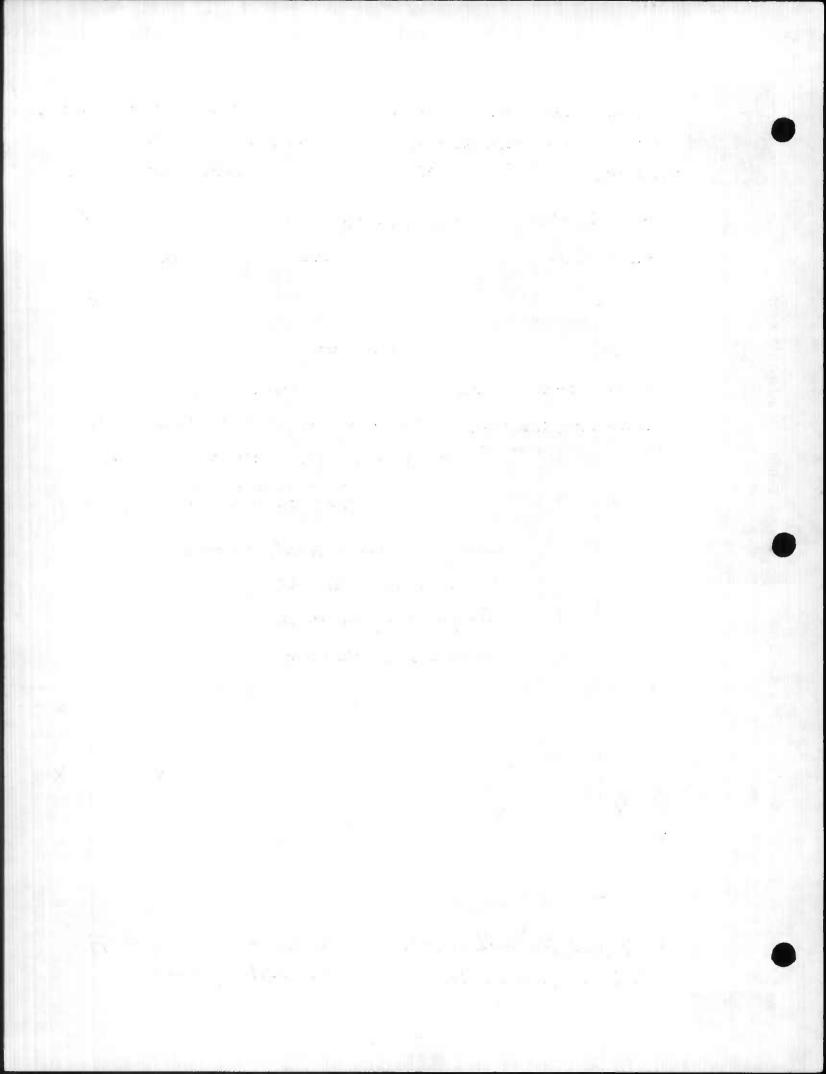
29b. Signature and title of certifier

29c. Licanse number

29d. Date signed (Month, Day, Year)

30. Nama and address of person who complated Prince Georg

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 25 1999

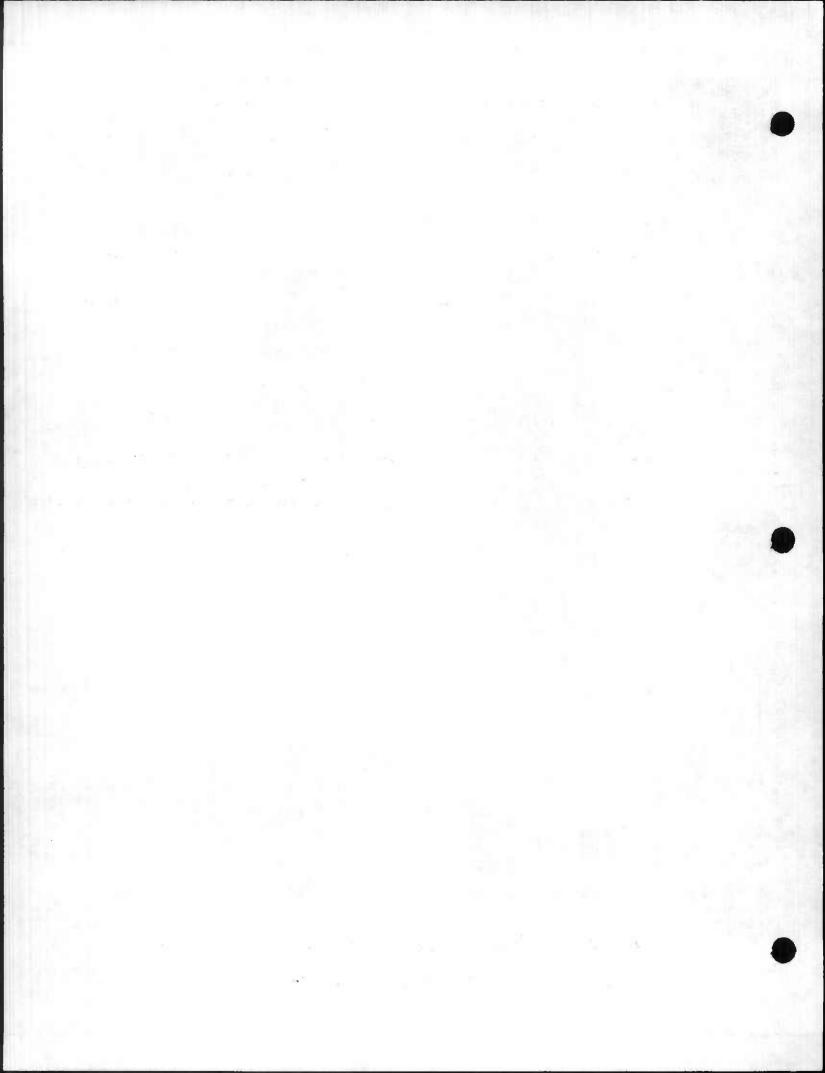


State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** John Joe1 Pitts, Jr. February 18, 1999 2:50 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** Randolph Hills Nursing Center Wheaton Montgomery If Under 1 Yaar | If Under 24 Hrs. Birthplece (Stete or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) **Funeral** Deys Months Hours 1⊠M 2□ F Yrs. 240-07-1934 Director July 2, 1917 North Carolina Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No Directo 258-1 Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? "natural", or flams 23s or 4011 Randolph Road 20902 United States Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 12. Wes Decedent Evar in U,S. Armed Forcas? 14. Race - Amaricen Indien, Black. White, etc. after 1 X Yes 2 No If Yas, Give Yeer or Detes: WWII 1 XNaver Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: å 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elemantery/Secondary (0-12) College (1-4or 5+) Clerical / Administrative Textile permit, Pages 1 and 2 should be file Department of Health and Montal Hy important; if feen Z7 is marked othe any Injury or other treatments 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be John Joel Pitts, Sr. Mary Leona Lamb 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Raletionship (Type, Print) Celeste R. O'Donnell (niece) 8806 Spring Valley Road, Chevy Chase, Maryland 20815 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 ☐ Buriel 2 🖾 Cremetion 3 ☐ Removel from State 2-19-99 Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specity) Chesapeake Crematory 22. Nama end Address of Fecility
Rapp Funeral Services, P.A. 21. Signature of Funeral Service Licensee 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or haart teilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical Metastatic Prostate Cancer Years Examiner Due to (or as e consequence ot): Examiner the deeth certificate be executed and Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): physician Box 68760 Physician/Medical the Dua to (or as a consequence of) 23b. Dtd tobacco use contribute to the cause of death? Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. P 24b. Wera autopsy findings available prior to should l Completed 24e. Wes en autopsy performed? completion of cause of death? 1 Yas 2 XNo 1 ☐ Yes 2 ☐ No al or Attanding Physician: 1 s efter death. Il Director: After this carifical ed in by the funeral director, p Be 25. Was case reterred to medical examiner? 26. Pleca ot Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2♥ No Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. tnjury et Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours of
 Funeral Dietely filled in Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, dete and plece, and due to the cause(s) end manner steted. To the I within 2 To the I 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 10 D08944 February 19, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragut Avenue, Kensington, MAryland Martin C. Shargel, M.D., 31. Date filed (Month, Dey, Year) 32. Registrar's Signatura State

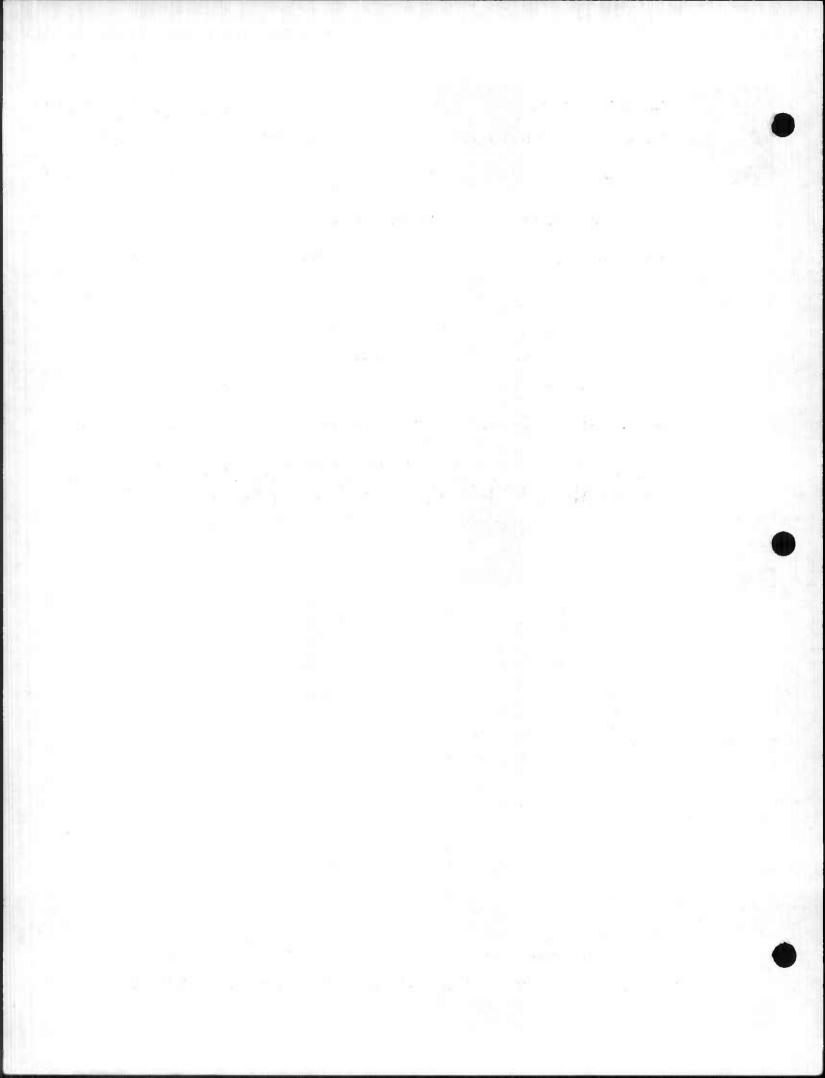
DHMH 16 Rev 6/95

Registrar

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		VERA ROGERS PO	RTER					Month FEBRUAR	Day	Year 1999	1220 A			
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	-	017-18-3159	Sex 1□M 2⊠F	7. Aga (In yrs. 81	last birthday) Yrs.	If Undar 1 Yaa Months Day			Year) 1917	9. Birthpla Country Massa	ca (Stata or F y) achuse t			
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to		MD Montgo	mery		Silver	Spring					1 Yas 2			
Sired	1	10e. Street and Number				10f. Zip Coda	9	1	0g. Citizan of	What Countr	y?			
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by Fune		11. Marital Status 1 □ Navar Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Fo	2 🔯 No va		Was Decedent of f Yas, specify Cu 1 ☐ Yas 2 ☒ No	Hispanic Origin? (Siban, Maxican, Puar Specify:	Specify Yas or No- to Rican, atc.)		ce - Amarica ck, Whita, at y: V				
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du		Elementery/Secondery (0-12)	Collega (red)							
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Be		George E. Roge						. Webb	VIAIOSII ODIIIAII	rarray				
F		19a. Informant's Name/Relationship			19b. Mailir	ng Addrass (Stree		ber, City or Town, Stata, Zip Code)						
		John M. Porter	(husb	and)			errace, S							
	2	20a. Mathod of Disposition			-	20c. Location		n, Stata						
		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Cematary, cramatory or other place) Gate of Heaven Cemetery 2/23/99 Silver Spri												
National Property	1	21. Signature of Funeral Service Lic	ensee	LC.)_ Ho	Nama and Add me, Inc	rass of Facility Fr 500 Un	ancis J. iversity	Collin Blvd.	s Fune West	eral			
an cal indicate Examiner and calculations are calculated and calculations and calculations and calculations and calculations are calculated and calculations and calculated and cal	23a. Part1. Entar tha diseasa, or co shock, or haart failura. List on	emplications that	aused tha daa			ring, MD	20901 c or raspiratory arr	ast,		Approximsta ntarvai Batwe				
	disease or condition rasulting in death) END STAGE CONGESTIVE HEART FAILURE Due to (or as a consequence of):													
sicia	F	Part fl. Other eignificant conditions	contributing to d	eath but not res	sulting in tha u	ndariying causa (given in Pert f.	23b. Dfd to	obacco uee co	entribute to t	the cause of			
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leted by							24a. Was a perfor	in autopsy med?	avali	a autopsy find lable prior to plation of cau aath?				
								1 □ Y	as 2⊠No	10	Yas 2□ N			
Be	2	25. Was casa refarred to medical axaminar?	Hospital:				Whoe	eth (Check only or						
D Be	1 ☐ Yas 2 ☐ No 27. Mannar of Death	1 1 1 1 1 1		ER/Outpatier 28b. Tima of	I 3LI DOA	4 Li Nursing I	Homa 5 Rasidance 8 Other (Specify) 28d. Dascribe how injury occurred							
ation		1 ☑Naturai 5 ☐ Pending		of injury th, Day Year)	Injury	W			,,					
Certification:	1 LdNatural 5 Pending 1													
	Cal Cer	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et tha time, data and place, and due to the causa(s) and manner as stated.												
			one) and manner stated. 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
Medical Certifi	2	(Check only 2 Medical Ex	and man	1		29c. Lica	nsa number	-8	nd. Date signe	id (Month, Di	uy, reary			
	2	(Check only 2 Medical Ex	and man	_11.	D.		15789	_	2/2	0 /99	ay, reary			
Medical Certifi	2	(Check only 2 Medical Ex	2		D _ п 23e) (Туре,	010	_	_	2/2	0 /99	ay, reary			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #7,2/23/99, BMW, Montg. Co. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Month Yee **Physician** THERESA 02 1999 11:15AM PEGGY PRICE 18 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not Institution, give street end number) Examiner MONTGOMERY 5012 NORBECK ROAD ROCKVILLE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours Min. 1 ☐ M 2 🛛 F 83 Yrs. NOV. 25, 1915 NEW **JERSEY** Director 053-12-9074 Usual Residence of Decedent with the Meryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show notified at ROCKVILLE 1 Yes 2 No MD MONTGOMERY Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number ? Is marked other than "natural", or itema 23a or traumatic event, the Medical Examiner must be a USA 20853 5012 NORBECK RD Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Status Biack, White, etc. Jemit. Pages 1 and 2 should be filed within 72 hours eiter Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural; or ite any finlury or other traumatic event, I'm Medical Eurifre 1 ☐ Yes ※ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Married 1 Yes 2 No altimore, Maryland 21215-0020 Specify Specify: WHITE by 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) OWN HOME 8 HOME MAKER 18 Mother's Name (First Middle Maiden Surname 17. Fether's Name (First, Middle, Last) ANNA (NOT AVAILABLE) CHARLES EKALO 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5012 NORBECK RD, ROCKVILLE, MD 20853 DAUGHTER SHARON COLLINS 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Ferenation 3 ☐ Removel from State Date 20c. Location - City or Town, State COMFORT CREMATORY 02-22-1999 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC of Funeral Service Licensee 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part 1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) YEARS /Medical HEART FAILURE CONGESTIVE Examiner Due to (or as a consequence of) Examiner The law requires that the deeth certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or as e consequence of): pue attending physician for use as the buria Box 68760 Physician/Medical Due to (or es e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o the signed by to 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown مَ by Division of Vital Records, 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy parformed? peen 198 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Be Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter deeth. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Sulcide 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and manner es steted.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier completely (Check only one) the th 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 0 DO 1191 02 19 1999 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) CULVER STREET, KENNSINGTON, MD 20895 9618 DR. RALPH COAN, MD,

DHMH 16 Rev 6/95

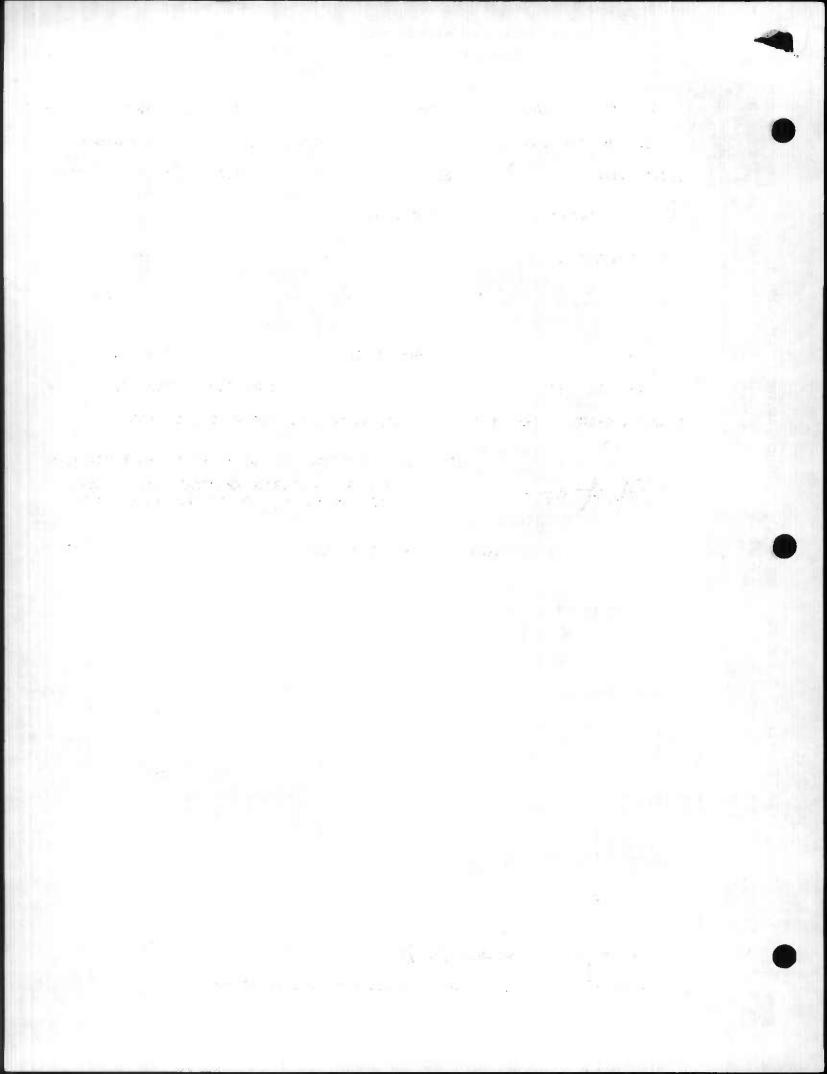
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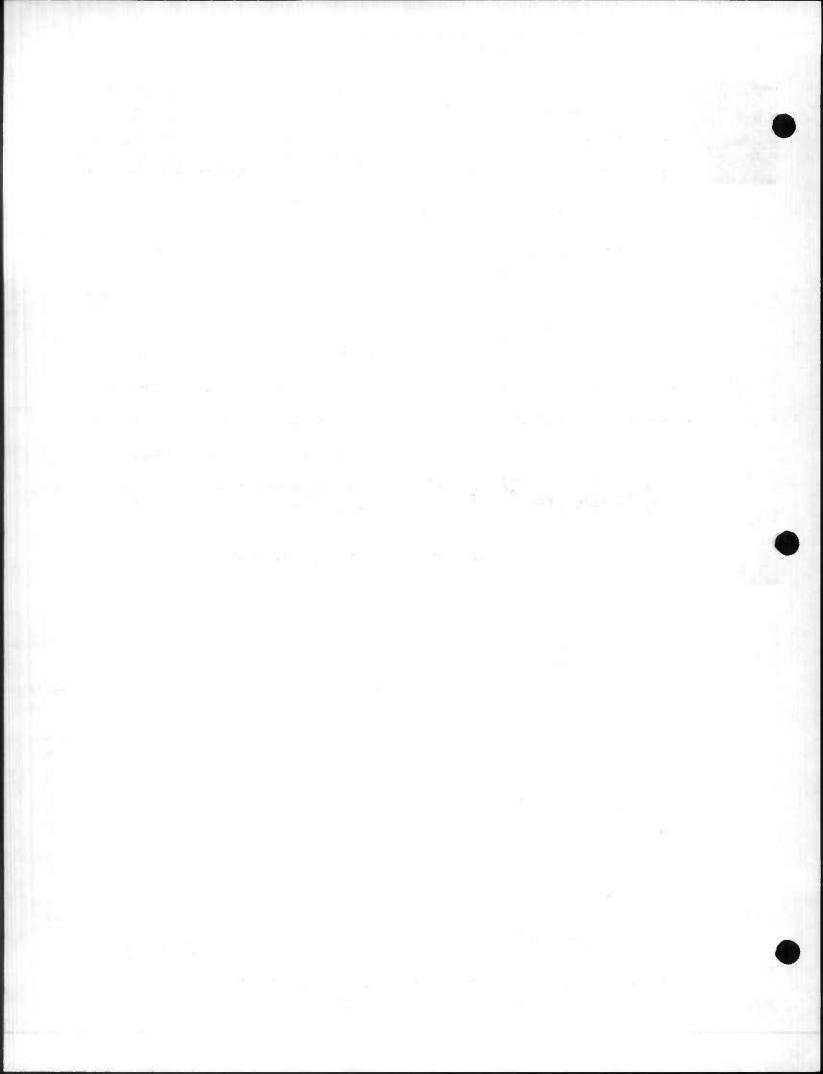
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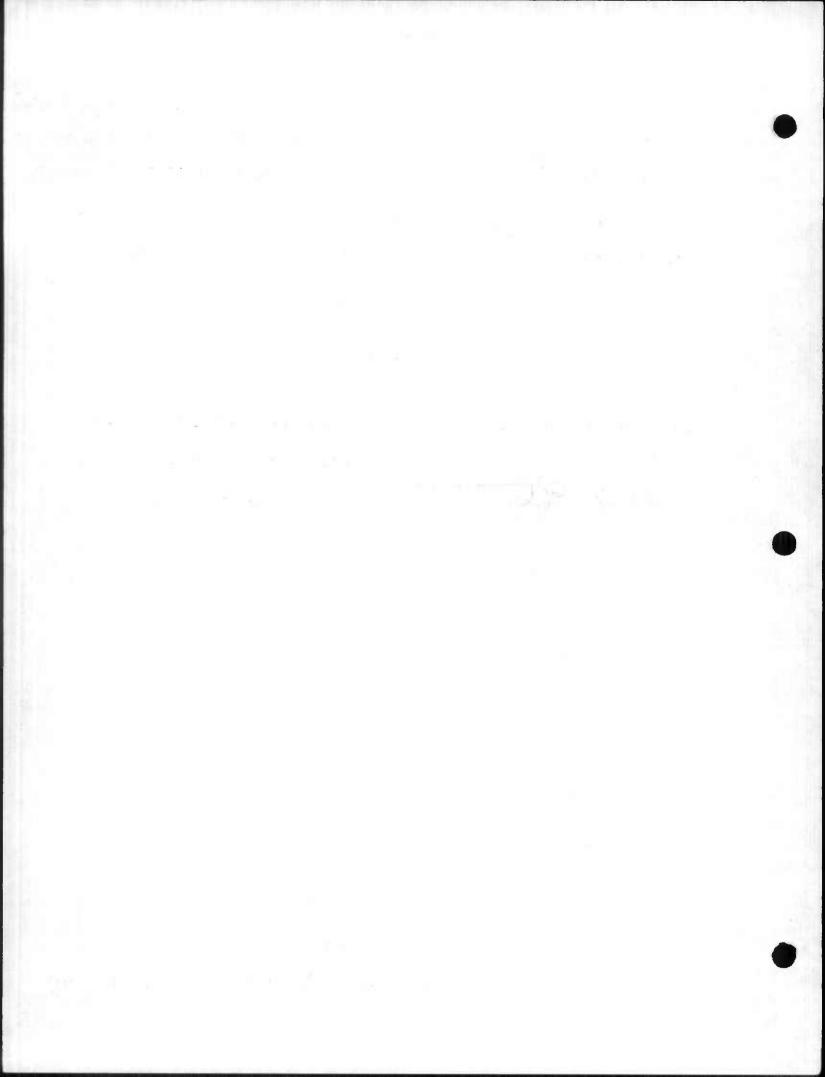
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State of Maryland / Department of Health and Mental Hygiene

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	23a or 28 usi be no	Funeral Director	10e. Street and Number 11424 Croom Roa	ad		10f. Zip Code 2 0 7		10	g. Citizen of V	What Country?	
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ore			20a. Method of Disposition 1 □ Burial 2 □ Cramation 3 □ F		b. Place of Dispo cematary, crai	osition (Nama of matory or other p	lace)	Data 2	Oc. Location -	City or Town, St	ata
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			30. Nama and addrass of person who co	emplated causa of death (I	tem 23a) (Type,	Print)	2 1 1				
	C		Michael Si 31. Data filed (Month, Day, Yaar)	b Allows 32. Registrar's Sig	11701	nivingstor	1 Rd, Suf	e101 F	+. Was	hington	MD
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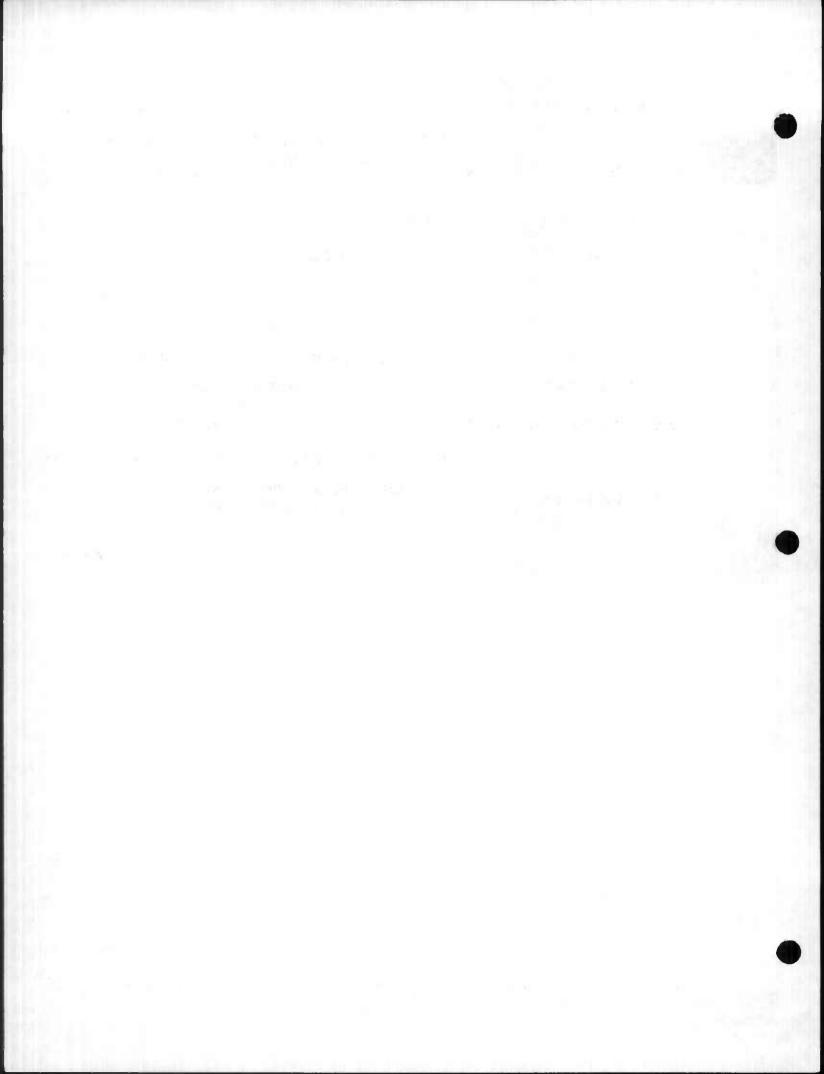


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** OLIVE MARY PATTON 21 FEB 1999 12:15 A.M. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death Examiner FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1 M 2 XF Days Months Hours 215 44 9082 Yrs. Director JULY 23 1914 Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 No Directo MARYLAND ALLEGANY **FROSTBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 73 BOWERY STREET 21532 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 🗓 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental hygiene. Important: If item 27 is marked other than °1 any injury or other traumatic event, the Next Elementary/Secondary (0-12) College (1-4or 5+) 9 HOMEMAKER OWN HOME 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middla, Last) Be CHARLES FRAM ANGELA THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Numbar or Rural Routa Numbar, City or Town, Steta, Zip Coda) 12 NEVADA AVE., NW, CUMBERLAND, MD 21502 ROSE MARIE DENTINGER / DAUGHTER 20b. Place of Disposition (Nama of comatery, cremetory or other place) 20a. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State ST. MICHAEL'S CEMETERY 2/24/99 FROSTBURG, MD 21532 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** abdoMINAL ANEURYSIN /Medical immediate Cause (Finel HOURS. disaasa or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner sician and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or injury that Initiated events resulting in death) Last Due to (or as a consequence of): physician s the buriel Box 68760 Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown SyndromE BRAIN þ 24b. Were autopsy findings available prior to 24e. Was en eutopsy Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certific; completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only ona) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 1º 27. Menger of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicide 29e. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier D25638 February 24, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 CHANG M.D. R+36 Frostburg PLAZa FROSTBURG, Maryland 21532 ms 32. Registrar's Signature

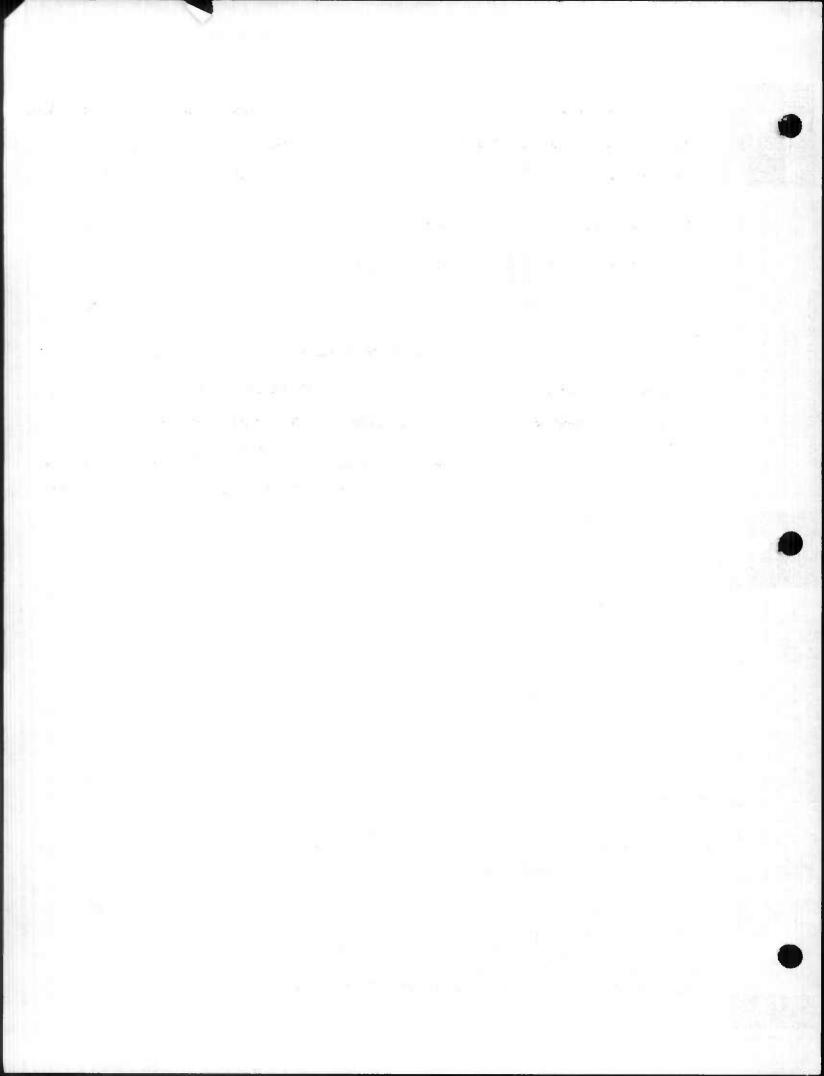
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State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 0 7 2 9 9

Physician The Ima_Mae_Price Examiner A Feathy Name of row institution, pins stores and number) A Lie gamy Country Nursing Home Lie and Country Nursing Home Country Nursing Home Country Nursing Home Lie and Country Nursing Home Country Nursing Home Lie and Country Nursing Home Country Homes Lie and Country Personal Section of Dealer Accountry Homes Lie and Country Days Homes And Lie						Certific	ate of	Death		Reg. No.	UI	200 00 00
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Allegany Country Nursens 6. Same 1900 - 1900	/Medica	al -		street and number)				4b. City, Town, or L	Feb.	20, 199	9 1	1:20 A
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23a. Part I. Entar the disease, or complications triff cales of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, intravallal cause fine disease or condition and the disease or condition	ortan ortan	-			Ros			y Z	3,1999	Cumberla	and, M	arylan
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	y filled		29a. Cartifiar 1 Certifying Phy	sician: To the best of	ot my know	ledge, daath occur	ad at tha tir	ma, data and place,	and dua to tha	ausa(s) and mar	nar as stated	d.
	Pletel	Da	(Check only 2 Medical Exami	ner: On the basis of	axaminatio	on and/or Invastigat	ion, in my c	pinion, death occur	red at tha tima, o	data and place, a	nd dua to tha	cause(s)
	# F 5		29b. Signatura and titla of certifor	1			29c. Licans	a number		29d. Data signed	(Month, Day	Year)
7 D33280 Feb 22, 1999	₹ F 8		4.11	1			1)22	22 073		Fob >:	199	9
30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print)			4	a de la constitución de la const		1	1179	210	l l	1 67 6	-, (/ /	/



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	1 - STATE REGISTRAR	SIAIE UF N	IARYLAND / DEI Cert	PARTMEN FIFICAT				MENT	AL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last) OF VANTE S	HAMAK	PATTE	ERSO	SN			2. DAT	E OF DEATH	19	VEAD	TIME OF CEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 1 1 M 2 - F	6. AGE (In yrs. lest birth		ER 1 YEAR	IF UNDER	24 HRS.	7. DAT	E OF BIRTH / orth, Day, Year)		Country)	NCE (State or Foreign
	9e. FACILITY NAME (If not institution, give s	itreet end number)		9b. Cf	TY, TOWN (OR LOCATIO	ON OF DE		0.1,1	9c. COUNT	Y OF DEAT	4 CAND
DIRECTOR	PRINCE GEOLGE.	S HOSPIT	AL CENT	ON C	HEV	ERC	4			PRIN	KE G	EORGES
<u> </u>	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT			CITY, TOWN								d. INSIDE CITY
	MARYLAND PRINC	E GEOR	CGES K	PIUER	COA	CE						LIMITS?
3AL	10e. STREET AND NUMBER				101	. ZIP CODE				10g. CITIZE	N OF WHA	COUNTRY?
FUNERA	53/6 - 62NO						73	-		-	S.A.	
BY FU	1 Never Married 2 Married 3 Widowed 4 Divorced		TEVER IN U.S. ARMEO YES 2 NO AR OR DATES	13	If yes, sp	ENDENT OF	, Mexice	n, Puarte	ilN? (Specify Yes o Rican, etc.)	or No-	Black, W	American Indian, hite, etc.
8	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDE	NT'S USUAL d of work don	OCCUPATIO	ON of working		16	Bb. KIND OF BUS	INESS/INDUS		4,46
	Elementary/Secondary (0-12)	College (1-4 or 5+) Iffe. Do N	OT use retired	.)	ist or working				,		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	0=	1.K	VAN		40 110711			ZNFA			
BE C	UNKNOWN										ATTA	RSON
0 8	19e. INFORMANT'S NAME (Type/Print)		19b. MAI	LING ADDRE	SS (Street a	and Number	or Rural F	Proude No	mber City or Town	State Zin C	oria)	
-	PRINCE GEORGES	HOSP.C	TR. 300	1 40	SP17.	AC A	ores	VE,	CHEU	ERL	4,00	020785
	20s. METHOD OF DISPOSITION 1	2) tottos	20b. PLACE AND D	ATE OF DISPO	OSITION (Na e)	ame of	2-	12	99 20c go	EV L	y or Town,	State (N)
	21. SIGNATURE OF FUNERAL SERVICE LIC	MU	C	22	Ceft 1	ADDRES	S OF FAC	/ K	USBIT	M C	MA	Myry
	23 PART i. Enter the diseases, or cahock, or heart failure.	complications that	caused the death.	Do not ani	ar the mo	da of dyin	ng, auct	aa ca	rdiac or reapi	ratory arrea	ıt,	Approximata
	MMEDIATE CAUSE (Final			-	-	40			4			Interval Between Onset and Death
J	resulting in death)	a. PREM	OR AS A CONSEQUENCE	1 1311	TH	AT	ZZ	W	eeks			
_			ERM LA									7117
CERTIFICATION	if any, leading to immediate		OR AS A CONSEQUENC									
5	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants	c	DR AS A CONSEQUENC	E OE								
H	resulting in death) LAST		NARY I	,	TUR	174						
	PART II. Other algolificant condition						bron In I	D	I			
ICAL		_ contributing to	seath but not readily	ing in tha t	maarrying	g cause g	IVEN IN	Part I.	24a. WAS AN PERFOR	MEO?	AVA	RE AUTOPSY FINDINGS RLABLE PRIOR TO MPLETION OF CAUSE
PHYSICIAN: MED									1 YES 2	LINO		DEATH?
ä	DID TOBACCO USE CONTI	RIBUTE TO CA	JSE OF DEATH	YES 🗆	NO 🗷	UNC	RTAIN	1 🗆			''] 123 2 B NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HO9PITAL:	26. PLACE OF									
IXSI	1 VES 2 NO	1 Inpatient 2	ER/Outpatient 3 DO	1	ursing Hom	e 5 🗆 Res	idence i	8 🗆 Oth	er (Specify)			
	1 Netural 5 Pending	(Month, On		TIME OF INJURY		URY AT RK? YES 2 .		28d. DE	EŞCRIBE HOW II	LJURY OCCUP	RED	
Э ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At homa, te	rm, street, fe			NO	28f. LO	CATION (Street e	nd Number or	Rural Route	Number,
TED	4 Homicide determined	building, e	rtc. (Specify)					City	y or Town, State)			
COMPLET	290. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINE											I manney as stated
	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICE						nth, Day, Year)
O BE	rommend	Land				D	47	95	8	D 2	-10-9	9
5	30. NAME AND ADDRESS OF PERSON WHO		OF DEATH (ITEM 27)		Pin	FA	1/5.	1-1	111.	40 7	1784	
		JZ. PILOISTRAT	3 STUNATURE	1	, , , ,	0,0	+CV	CN	29 11.	2 66	,,00	'
	MAR 0 8 1999	Deper	D.	Ann	11.1							

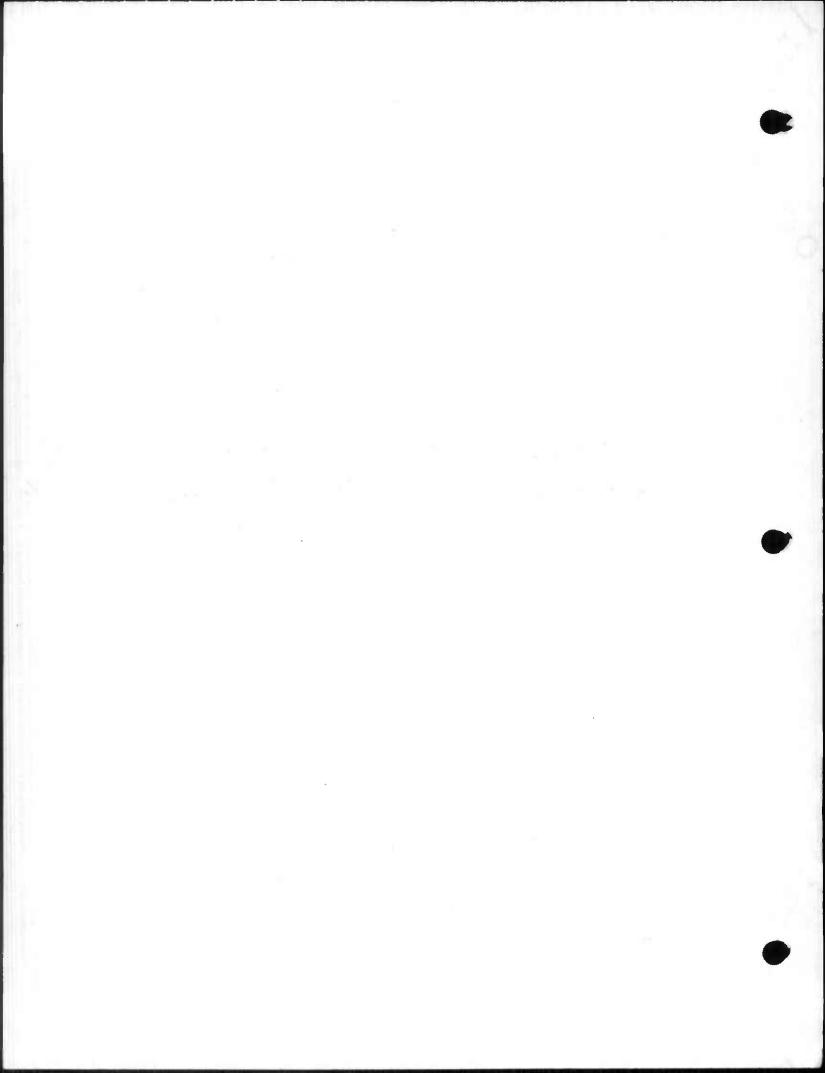
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

OHMH-16 Rev 1/89



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death , Month Dey Year + 10 FUN 4 22 , 1999 4b. City, Town, or Location of Death | 4c. County of Death Mildred Marie Robertson 1999 4a Facility Name (If not institution, give street and number) Washington County Hospital Washington Hagerstown If Under 24 Hrs. If Under 1 Year 9. Birthplaca (State or Foreign Country) Marykand 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 10M 20F Vrs 78 220-46-4960 Usual Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. toside City Limits 1 Yes 2 No Washington Hagerstown Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21742 U.S.A. Leiter St. Apt. 10 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Carrie Grace Poper William Earl Seilhamer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Kenneth L. Robertson (Son) 21416 Leiter Mill Rd. Hagerstown, Md. 21742 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Borrat 2 Cremation 3 Removed Smithsburg Crematory Feb. 25,1999 Smithsburg. Md Signature of Funeral Service Licen 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home lemus o Smithsburg, Md. 21783 23a Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one cause on each line. Approximate Intervat Between Onset end Death Immediate Cause (Final disease or condition resulting in death) 1-200 Premmaria Due to (or as a consequence of): Congentin Kenr Failur The Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted evants Due to (or as a consequence of): Anteno relamitic Cardiarane Dines that initiated evants resulting in death) Last Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 4 thknown Reme inspicion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 alter Direm 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Date of tnjury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred

Examiner attending physician and for use as the burial-transit signed by t or Attending Physician: The law after death.

Director: After this certificate has I Division Hospital of 24 hours a Funeral D To the Hosp within 24 ho To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or flame 23s or 28s-f ahow the Mexical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is merked other than "nat eny finiury or other traumatic event, the Medical DRGS.

Physician

/Medical

Examiner

Physician/Medical

by

Completed

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Certification:

edicai

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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25. Wes case raferred to medical 1 Yas 2 10 27. Manner of Death 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 4 I Homicida

29a. Certifier (Check only one)	Certifying Physician: To the best of my knowled Medicat Examiner: On the basis of axamination and manner stated.		
29b. Signeture ar	nd title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

TOSTL MO

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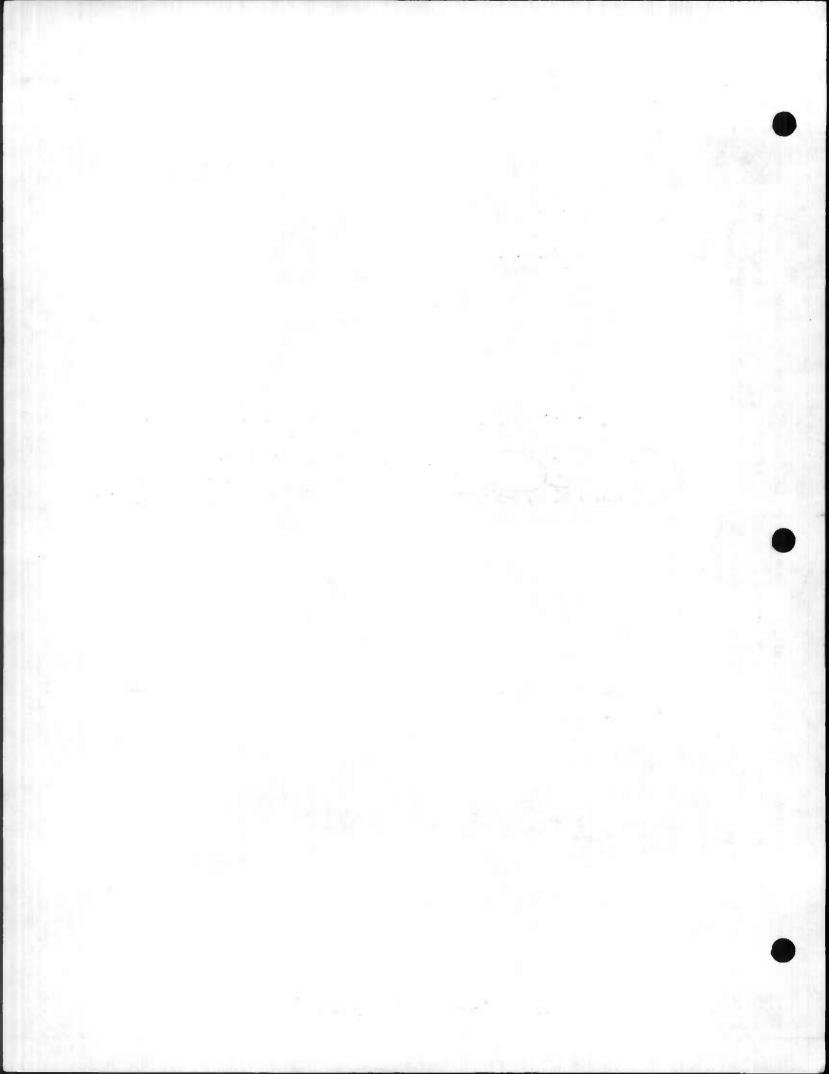
FEBRUARY 23,1995

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Datta 31. Date filed (Month, Day, Year)

FEB 2 4 1999

344 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygien 9 9 7302

		Otato or marynar		icate of			Reg. No.	01302						
Physiciar /Medica		Daniel Llo	yd Rowe			2. Date of Dec Month Februa	Day	3. Tima of Death 1999 16 11						
Examine	An Carlting his one of the and in although a saine				4b. City, Town, or L Hagers			of Death hington						
Funeral Director	5. Social Security Number 220-09-7320 6. Security Number 15	7. Age (In yrs. 85	MA DIEGO DE DE CONTROL	Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da August	h v. Year)	9. Birthplace (State or Fore Country) Maryland						
ahow det	Usual Residence of Decedent 10a. State 10b. County Penna. FRankli:		ly, Town or Location					10d. Inside City Lim						
ifter death with the Mar free name 23a or 28a-fai free mant be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of W							
a 23a	43 Orchard Circ		0 40 11/-	1722		it-VN-	U.S.A	American Indian,						
		12. Was Decedent Ever in U Armed Forces? 1 MYes 2 □ No IfYes, Give Year or Dates:		Yes 2 No	ecify Yes or No Rican, etc.)	Specify:	k, White, etc.							
vithin 72 ne.	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			d of work done NOT use retire		16b. Kind of Bus								
and 212 be filed withintel Hyglene. d other than avant, tre M	12 17. Father's Name (First, Middle, Last)		Trac	tor-Tra	ilor Open		Trucki Maiden Sumame							
	Ira W. Row	2			Julia	Prudenc	e Shank							
and	19a. Informant's Name/Relationship (Ty	pe, Print)			and Number or Ru									
Te, N Tand Health em 27	Neddie N. Rowe 20a. Method of Disposition	20b. F	Place of Dispositio	n (Name of	Circle Gr	eencast]		17225 City or Town, Stata						
Pages nent of I	1 Durial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emovat from State	cemetery, cremeto lar Hill			2/26/99		castle, Pa.						
Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27 any injury or other it anges.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zimmerman And Son Funeral Home												
m 89 E 2 A	H. Marlen 2	under.	45	S. Car	lisle St	. Green	astle.							
Physician /Medical	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final							Approximate Interval Between Onset and Death						
Examiner	disease or condition resulting in death) Due to (or as a consequence of):													
cete be executed physician and s the buriet-transit														
- 04	resulting in death) Last													
BOX eath cert attendin I for use						l an ard								
dS, F.O. BOX of sires that the death certification of the attending of be detached for use as do by Physician Metal	Part II. Other significant conditions con		tribute to the cause of dea 3 Probably 4 Unkn											
request should				3,5		24a. Was perfo	an autopsy med?	24b. Were autopsy finding available prior to completion of causa of death?						
T VITAI REC ysician: The law is certificate has director, page 2						10	res 2010	1 ☐ Yes 2 ☐ No						
Of Vita Physician: this certific and director,	25. Was case referred to medical examiner?	lospital:	/	Ott	26. Place of Dea									
Physic priths or praidire	TU Yes ZLIPNO	28a. Date of Injury	ER/Outpatient : 28b. Time of	3□ DOA 28c. Inju	4 LI Nursing H		dence 6 Other							
DIVISION C tail or Attanding P is after death. al Director: After ti led in by the funera Certification:	1-Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At h	ome, farm, street,	M 1□	k? Yes 2⊟No	281. Location (Street and Number or Rural Route Number,								
DIVISION O To the Hospital or Attanding Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	4 Homicide 29a. Certifier H Certifying Physics	building, etc. (Specifican: To the best of my kno	(y) wledge, death oc	curred at the ti			cause(s) and mai							
To the Hospital within 24 hours a To the Funeral I completely filled		er: On the basis of examina and manner stated.		igation, in my o	pinion, death occu	red at the time,	date and place, a	and due to the cause(s)						
To the To the Com	29b. Signature and title of certifier	2		29c. Licens				(Month, Day, Year)						
	30. Nama and address of person who co	mpleted cause of death (Iten	n 23a) (Type, Prin	1	7885									
Santa	Dr John Hor	nbaker 32. Registrar's Signa	11110		cal Co	ampus	Rd.	Hag Md						
State Registrar	EED 0 4 100	19 Deperte	19.	board	21	-		*						

NAME: ROWE, DANIEL LLOYD 08/05/13 85 / M

нзоз9990084

DOS:



State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1999 06:2 ELNOR MAXINE ebruary /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death / 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year Birthpiece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F Yrs 214-76-9850 65 Director WEST VIRGINIA Usual Residence of Decedent ital Hyglene. Id other than "natural", or frama 23a or 28a-f ehow event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 N No Director MARYLAND WASHINGTON ROHRERSVILLE 10a. Street and Number 10f. Zip Code 10o. Citizen of What Country? 4250 MAIN STREET 21779 U.S.A. Funeral 14. Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ₩idowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) COOK RESTAURANT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Nem 27 Is marked othe any injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 10 HARRY HESS EMMA GRUBB 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JERRY R. ROW/SON 4404 MAIN STREET, ROHRERSVILLE, MARYLAND 21779 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/21/99 BOONSBORO, MARYLAND BOONSBORO CEMETERY 21. Signature of Fuperal Service Like 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 au 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final Cerebrauascula acuta 0-24600 diseese or condition resulting in death) Examiner Due to (or as a consequence of): Vegesle-Physician/Medical Examiner diserse Athoroschlerstic years sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of) physician s the burial Box 68760, Due to (or as a consequence of): signed by the aid be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Per. phone Vescoler Records. δ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 3) Personative acingn page 2 s has distuse 5000-2 12000-4 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Attending Physicien: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 1 Inpatient 2 ER/Outpatient 3 DOA After this Division of 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Neturai 2 ☐ Accident 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 6 Could not be determined 3 Sulcide 28e. Piece of injury - At home, tarm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 5 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ICE IN 1) 38764 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Hzge-11. m MD 21745 Suite 100

Registrar **DHMH 16 Rev 6/95**

State

Eldor

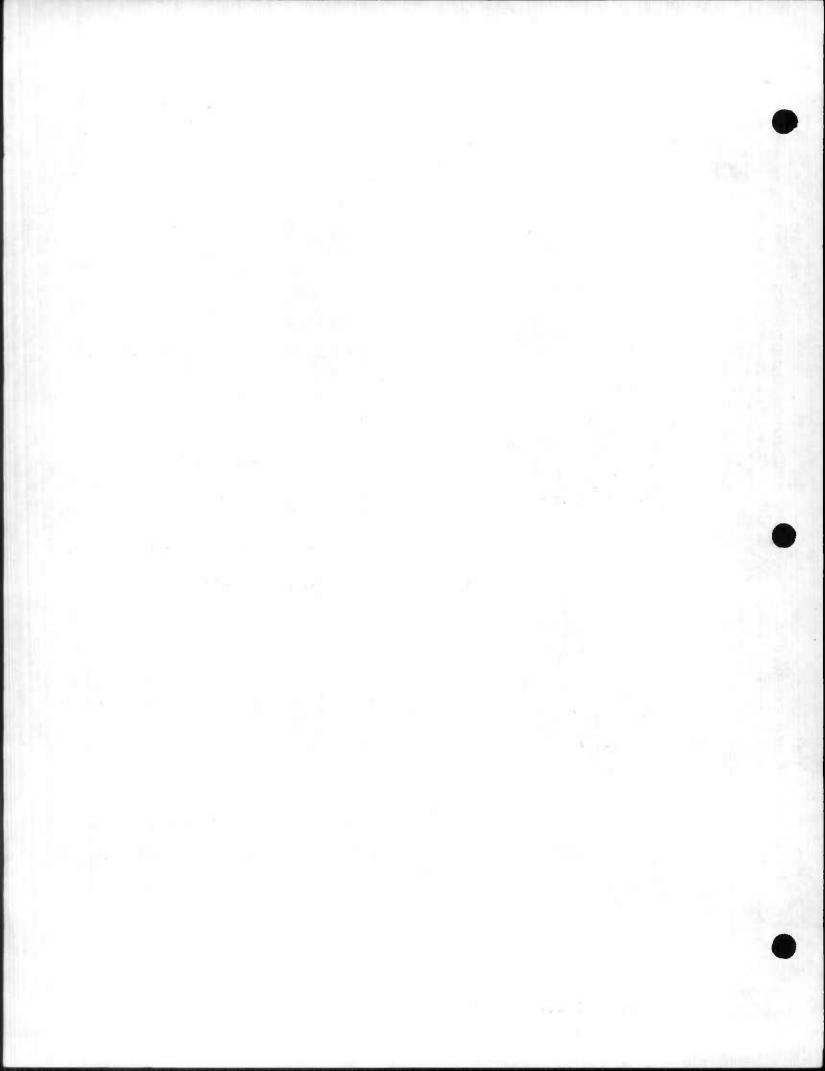
11110 made

32. Fégistrar's Signature

Rd

RIGGLE, MA

31. Date filed (Month, Day, Year) FEB 1 9 1999



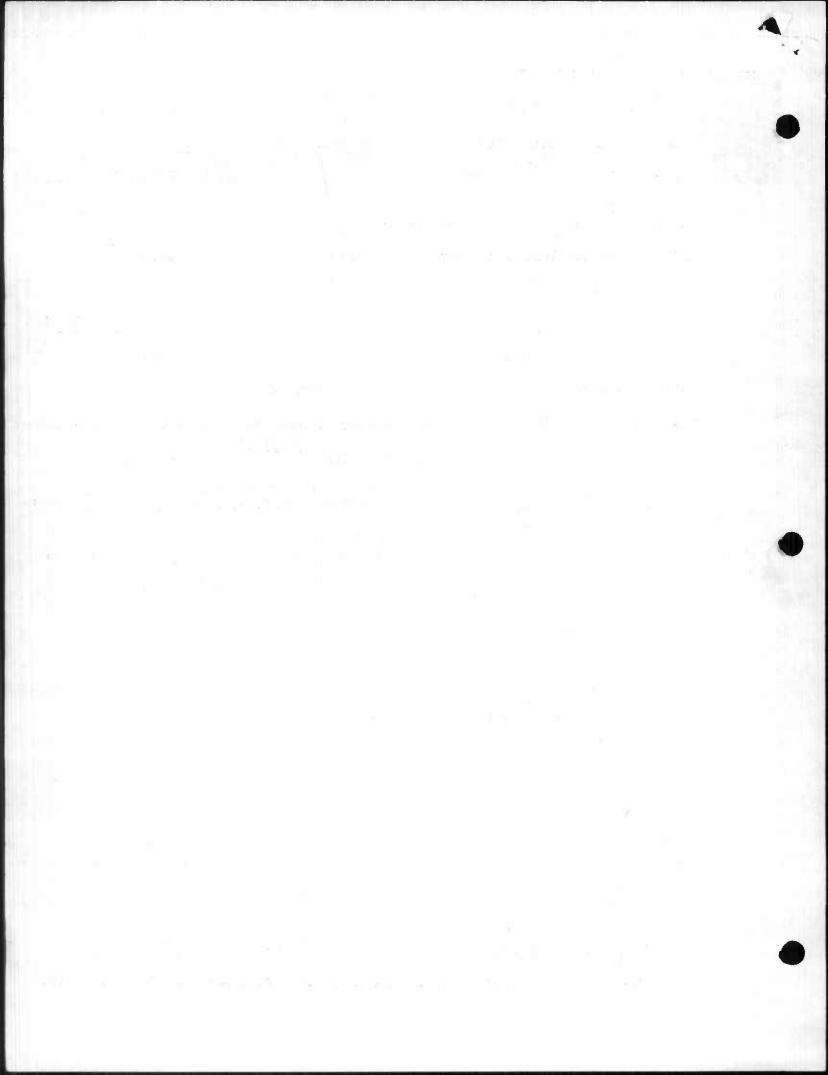
State of Maryland / Department of Health and Mental Hygiene 9 9 0 7 3 0 4

							C	Pertifica	ate of	Death			Reg. No.	0.5	0 1	,
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Physicia /Medic		Dougla	as E	dward	Rope	r						Ebru		17.19	199	09:0
Examin		4a Facility Name (Washingt	If not institutio	n, give street	and number) spital					4b. City, Tov Hager	vn, or Loca	ation of Deat	th 4c.	County of the shing	Death ton	
Funeral Director		5. Social Security N 196–44–6	Number 327	6. Sex 1 1 1 2 M 2		10 (In yrs. 142	last birthd	Month	der 1 Year Days	If Under a	Min.	B. Date of Bi (Month, D.)			Birthplac Country	e (Stata or F
2 >		Usual Residenca o	Decedent 10b. County			10a Cit	ty, Town o	. Location								Incid- Cit. I
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h the Marylar r 28a-f ahow	ect	10e, Street and Nu		rey		ria	LCTHS		Zip Code				10a Citi	zen of Wha	* Country	200
23a or	Funeral Director	709 New		venue					401			USA				r
re, Maryland 21215-0020 1 and 2 should be filed within 72 hours effer death with the Maryland Heelth and Mental Hygiene. Heelth and Mental Hygiene in zero the marked other than "natural", or frems 23s or 28s-1 show other traumatic event, the Medical Emission must be notified.	by	11. Marital Slatus 1 ☐ Never Mari 3 ☐ Widowed		ried 1 [as Decedent E med Forces? Yes 277 Yes, Give ar or Dates:		l,S. 1	13. Was Dec If Yes, s _i 1 ☐ Yes		in? (Spec , Puerto R	Rican, etc.) Bla			American White, etc Lack		
5-0 72 hc	Completed	(Spe	15. Deceden	t's Education	oleted)		16a. Decedent's Usual Occupation (Give kind of work dona during most of workii life. DO NOT use retired)						16b. Ki	nd of Busin	ess/Indus	try
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Maryla d2 should ith and Men 7 is marke		19a. informant's N								and Numbe					are, Zip Co	ode)
or Healt item 2		Lois Ann Roper/ Mother 1942 South West Blvd. Warren, 20a. Method of Disposition (Name of Date									_	44485 cation - Cit	v or Town	State		
Baltimore, semit. Pages 1 and popertment of Heal moortant: If Item 2 my injury or other Mice.		1 M Ruriat 2 Cramation 3 Demoval from State cemetery, crematory or other place)									rneysville,W Va.					
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Baltimor permit. Pages Department of h important: If its any injury or of once.		23a. Pert1. Enter t shock, or hea	00 /	7	12. Y	DE	372	Burner	Trac	de Ser	vices	1037	Dua:	l Pla	ce	
/Medical Examiner	ficate be executed by physician and street buriel-transit and edical Examiner	Immediate Cause disaase or condition resulting in death)	(Final on	a		Due to (c	or as a con	o je	lossa of):	16	leed	2			+	trs
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. 5 0 0	Physician/	Pert II. Other signif	licant condition	ons contributir	ng to death bu	it not res	ulting In th	e underlying	g cause gi	ven in Pert I.		23b. Did	tobacco	uss contri	bute to th	e cause of d
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Te se	:uo	27. Manner of Deat	h 5 🗆 Pendin	28a	. Date of Injur (Month, Day	y Year)	28b. Tim Inju		28c. Inju	ry at rk?	28	3d. Describe	how injur	y occurred		
Division or Attending after death. Director: After d in by the fune	edical Certification:	2 Accident 3 Suicide 4 Homicide	investi	gation not be	too M 1 Ves 2 No 28e. Place of Injury - At home, farm, street, factory, office 28f. Location						Bf. Location City or To	ocalion (Street and Number or Rural Route Number ity or Town, State)				
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DIVI To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medica		litle of certifie	an	ly fle	ted.	n 23a) (Tyi	2		se number	66	2		te signed (f		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Amend #7.2/22/99, BMW, Montg.Co. ITEMS: #1 PER MD #8, 16 PER INFORMANT G770 4-16-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Van EDWARD JOHN ROSENBERG February 18, 1999 10:50 PM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carriage Hill Nursing Home Montgomery Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs 6 Sex 7. Aga (In yrs. last birthday) FEB. 4 Birthplaca (State or Foreign Country) **Funeral** Days t√DM 2□F Hours Min 83 Yrs. Director 198-05-4028 Feb. 14, 1916 Philadelphia, PA Usual Residence of Decedent the Maryland 10a. State District Of County 10c. City. Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 Tr Yes 2 □ No Columbia None Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4501 Connecticut Avenue, NW, Apt. 803 20008 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify by Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry TECHNICAL RESEARCH & DEVELOPMENT LAB filed within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Years Head Librarian Textiles is marked other permit. Pegas 1 and 2 should be file.
Department of Health and Mentel Hy
Important: If item 27 is marked other
eny injury or other traumatic avanta 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marcus Rosenberg Dora Schwartz 2 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Rosenberg, Wife 4501 Connecticut Ave, NW, #803, Washington, DC 20008 20b. Place of Disposition (Name of cemetery, crematory or other place) 2/21/1999 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Montefiore Cemetery 4 ☐ Donation ゟ ☐ Other (Specify) Rockledge, PA 21. Signatury of Funeral Sarvice Licenses 22. Nama and Address of Facility STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, ul D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner Chorclerol Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury ettanding physician and for use as the buriel-trar Due to (or as a consequence of): Box 68760. The law requires that the death cartificate be Physician/Medical that Initiated events resulting In death) Last Dua to (or as a consaguanca of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings avallable prior to completion of cause of death? Completed 24a. Was an autopsy performad? paga 2 s 2000 certificata of Vital 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: Aftar Division or Attending 1 Naturel 2 Accident 5 Pending investigation s after death. 1 Yes 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Hospital edical 29a. Certifier Certifying Phyaiclan: To the best of my knowledge, death occurred at the time, dete end placa, and due to the ceuse(s) and manner as steted.

Medical Furniner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. To the Hosp within 24 hor To the Fune completaly fi one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Paul Noone, M.D., 50 West Edmonston Drive, Suite 207, Rockville, Maryland 31. Date filed (Mor 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q

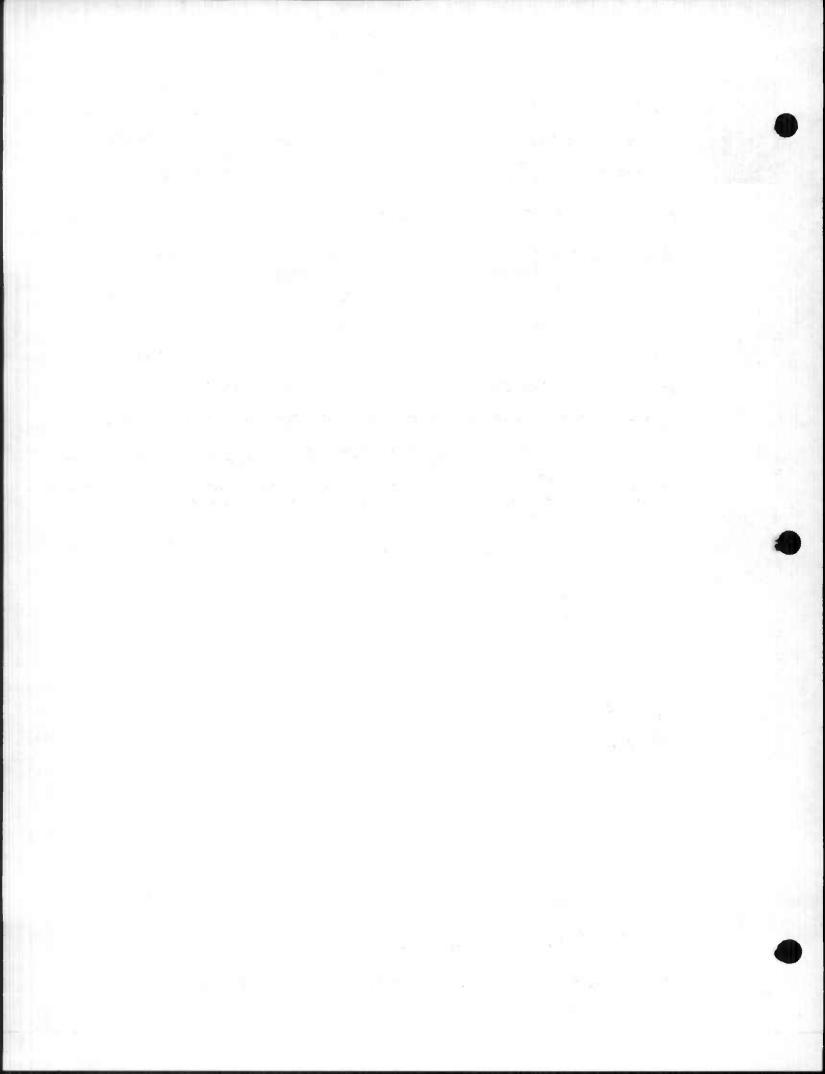
Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Vaar RUTH BEASLEY FEBRUARY REGITKO 22,1999 /Medical 11:55am 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL MANOR TALBOT If Under 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 T F Days Hours 89 **Yrs** Director 410-28-8907 SEPT.16,1909 TENNESSEE Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examinar mant be notified at 10d. inside City Umits TALBOT Director EASTON 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMAN'S LANE 21601 USA death Funeral 12. Was Dacedant Evar in U,S Armed Forces? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelih and Mental Hygiene. Important: if Item 27 is merked other than "natural", or her any injury or other treumetic event, the Medical Examine Black White atc 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo WHITE by Specify: 3 Widowed 4 □ Divorced Completed 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Be JAMES WILLIAM BEASLEY CLEO ROBERTS 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) CAROLINE R. BOUTTE/ DAUGHTER GRAYBANKS FARM, 27640 VILLA LANE, EASTON, MD 21601 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place)
CHESAPEAKE CREMATION 1 ☐ Burial 2 X Cremation 3 ☐ Ramoval from State 2-25-99 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CENTER, LLC 22. Name and Address of Facility 21. Signatore of Funeral Service Licans FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 Part1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one causa on each line. Approximate Interval Between Onsat and Daath **Physician** 5d /Medical Immediate Ceuse (Final disaasa or condition rasulting in death) Neumonia **Examiner** Due to (or as a consequenca of): Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last pue Due to (or es e consequence of): P.O. Box 68760. attending physician for use es the burie Physician/Medical the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? the 2 1 Tyes 2 No 3 Probably 4 ™Unknown signed be det Records, þ The lew requires 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed hes 2 page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics stely filled in by the funeral director, I Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2₽No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) and manner es steled.

2 Medical Examinar: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and manner stated. 29e. Certifier To the Hosp within 24 hor To the Fune completely fi Medical 29b. Signatura and title of certifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Year) 99 22 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) RICHARD A. BURGOYNE, M.D., 607 DUTCHMAN'S LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 1999

DHMH 16 Ray 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 9

If Under 1 Year

10f. Zip Code

Certificate of Death

CUMBERLAND If Under 24 Hrs. 8.

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U	1	0	U	- 1

Physician	
/Medical	k
Examiner	

Director

Funeral

by

Completed

LEE ANNA REID

1. Decedent's Name (First, Middle, Last)

2. Date of Death Day Month Vear FEBRUARY 19,1999

3. Time of Death 4:40 AM

10d. Inside City Limits

4a Fecility Name (If not institution, give street and number)

4b. City, Town, or Location of Death 4c. County of Death

Funeral Director

7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner maint be notified at

with the Maryland

deeth

72 hours after

Baltimore, Maryland 21215-0020

241-10-1033 Usual Residence of Decedent 10a State 10h County

Min Months Days Hours

8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) June 22, 1909 South Carolina

5. Social Security Number

Clover

10c. City. Town or Location

7. Age (In yrs. last birthday)

89

1 N Yes 2 No

10e. Street and Number

603 North Main Street

MEMORIAL HOSPITAL & MEDICAL CENTER

1□M 2⊠F

6. Sex

York

29710

10g. Citizen of What Country? USA

ALLEGANY

1 ☐ Never Married 2 ☐ Married

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

Black, White, etc. Specify: White

14. Race - American Indien.

3 X Widowed 4 □ Divorced

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

16b. Kind of Business/Industry

Elementary/Secondary (0-12) Unknown

Winder

Textiles Mill

17. Father's Name (First, Middle, Last)

William Andrew Cook

18. Mother's Name (First, Middle, Meiden Surname) Bessie Carroll Stewart

19a. Informant's Name/Relationship (Type, Print)

19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

Paul Cook/Son

Rt. 2, Box 232-B 20b. Plece of Disposition (Name of cemetery, cremetory or other place)

Keyser, WV

20e. Method of Disposition

1 XBuriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

Woodside Cemetery

Dete 20c. Location - City or Town, Stete Feb. 22 1999

Clover, SC

21. Signature of Funerel Service Licensee

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Rotruck-Smith Funeral Home 85 S. Main Street

26726 Keyser,

Physician /Medical Examiner

physician end the burial-transit certificate be asscuted

for use as

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been signed t

certificate

this After thi

Director:

To the Hospital or Attention 24 hours after des To the Funeral Directo completaly filled in by the

director,

Box 68760.

P.O.

Division of Vital Records.

The law requires that the deeth

or Attending Physician:

death.

Examiner

Physician/Medical

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Completed

Be

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Certification:

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permit. Pages 1 and 2 should be filed within 7 Department of Haalth and Mentel Hygiene. Important: If Item 27 is marked other than "read any injury or other traumatic event, the Med Botte.

disease or condition resulting in deeth)

Immediate Cause (Final

lumones

Due to (or es e consequence of)

Approximete Interval Between Onset and Death

Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other afgnificent conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown

24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy

1 Yes 2 No

1 ☐ Yes 2 No

25. Wes case referred to medical 1 Yes 2 No

27. Manner of Death

Natural

2 Accident

4 Homicide

3 Suicide

5 Pending Investigation

6 Could not be

28e. Dete of Injury (Month, Day Year)

1 inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes 2 No

26. Place of Death (Check only one)

29a. Certifier (Check only one)

🔛 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the ceuse(s) and manner es stated. Termying Priysician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

D 28910

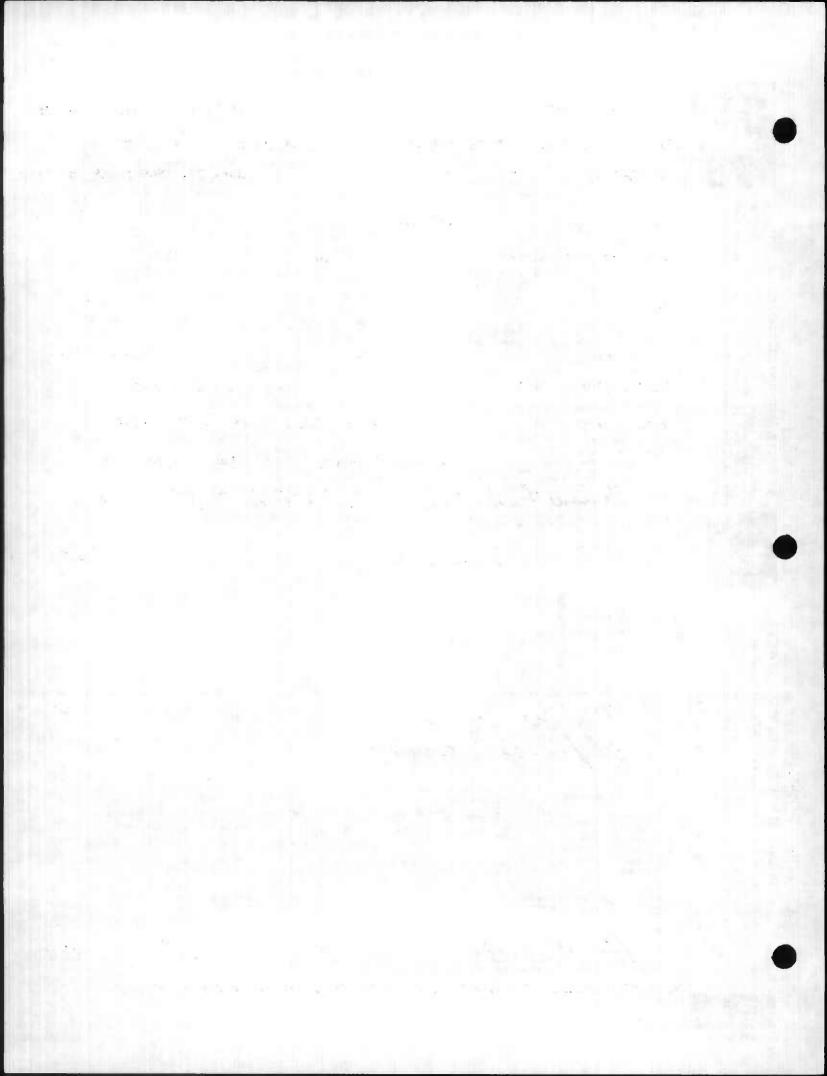
30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

H. CURTISS MERRICK M.D., MEMORIAL MEDICAL BUILDING, CUMBERLAND, MD 21502

31. Dete filed (Month, Day, Year) State Registrar

32. Registrer's Signature

150



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 125 ROBBINS DOROTHY 99 26 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not Institution, give street end number) Calvert County Nursing Home Calvert Prince Frederick Months Days Hours Min. Sept 19,1926 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Kentucky 1□M 2√F Months 386-14-8609 72 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20678 85 Hospital Road U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Coilege (1-4or 5+) Elementery/Secondary (0-12) 10th Animal Care Groomer 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Edna Miracle James Miracle 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Debra Hoopes 307 Wolfe Street Alexandria, VA 22314 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete XXBurial 2 Cremation 3 Removal from State Stafford Memorial Park 3/5/99 Stafford, Va 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mountcastle Funeral Home Woodbridge, VA 22191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting In deeth) NSPIRATION PNEUMONIA DA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical **Examiner** The lew requires that the death certificate be executed

Physician

/Medical

Examiner

Direct

Funeral

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Completed

Funeral

Director

the Meryland

permit. Peges 1 and 2 should be faed within 72 hours after deeth with the Merylan Department of Health and Mental Hyplans. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

or Attending Physician:

Hospital

death.

To the Hosp within 24 ho To the Fune

filled in by

edicai

Examiner physician and the buriel-transit Physician/Medical signed by the e by Completed peen s page 2 hes certificate funeral director, Be 2 this Certification: Affer 24 hours after death Funeral Director:

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No

29b. Signature and title of pertition

29a. Certifier (Check only one)

27. Manner of Death Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 28a. Date of Injury (Month, Dey Year)

28b. Time of

28e. Placa of Injury - At home, farm, streef, factory, office building, etc. (Specify)

28c. injury at Work? 1 Yes

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

28d. Describe how injury occurred

unn 30. Name and address of person who compa death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month Day Year) - 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 7 2 0 0

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Funeral Pirector	1	5. Social Security N 193–24–2	2331	6. Sex / 1□ M :			lest birthday) 1 Yrs.	If Under 1		nder 24 Hrs. urs Min.	8. Date of B (Month, D August	irth Pay, Year 2, 190	7	9. Birthple Counti	Per	nna.
3		Usual Residence of 10e. Stete	t Decedent 10b. County			10c Cit	y, Town or Lo	cation						10	d. Inside	Obellie
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then then		Elementary/Seco	ondary (0-12)	C	ollege (1-4or :	5+)		emaker			Home					
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S T S		19e. Informant's Na	ame/Relationshi	ip (Type, Pi	rint)		19b. Mailin	g Address (S	Street end N	um <i>ber</i> or Ru	r or Rural Route Number, City or Town, State, Zip Code)					
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Opposite the law term to the control of the mining of the control of the The second has the second seco STATE OF THE PARTY
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Dey 1999 10:08 PM Robert Palmer SHANK 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Washington County Hospital Hagerstown

| Munder 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Washington 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6 Sax Birthplace (State or Foreign Country) 10XM 2□F Months Days Yrs 74 Aug. 26 1924 220-18-3298 Maryland 10a State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11008 Pin Oak Terrace 21740 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?
1 (X) Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Merried 2 Merried 1 Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Test-Man Telephone Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Paul R. Shank Olif Palmer 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11008 Pin Oak Terrace Mildred D. Shank - Wife Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriat 2 XCremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2/19/99 Hagerstown, Maryland Hagerstown Crematory 21. Signeture of Funeral Service Licensee 22 Name and Address of Fecility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) heart disease by pertucuse Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown Resperalory faclus 24b. Wera eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? bleeding - cause not determed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

/Medical Examiner Box 68760, Division of Vital Records, P.O.

attending physician and for use as the burlai-transit signed t peen n 24 hours efter death.

Ne Funeral Director: After the pletely filled in by the funeral To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After

Physician

/Medical

Examiner

Directo

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Certification:

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Funeral

Director

traumatic event, the Medical Examiner must be notifie

1 and 2 should be Health and Mental

Pages nent of h

altimore,

Repartment of Health and Menta reportant: If Nem 27 is marked

Physician

State Registrar

31. Date filed (Month, Day, Year) FEB 22

HUROLD

29b. Signature and title of certifier

Hurald NI with of his

1999

(Check only one)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Trutch

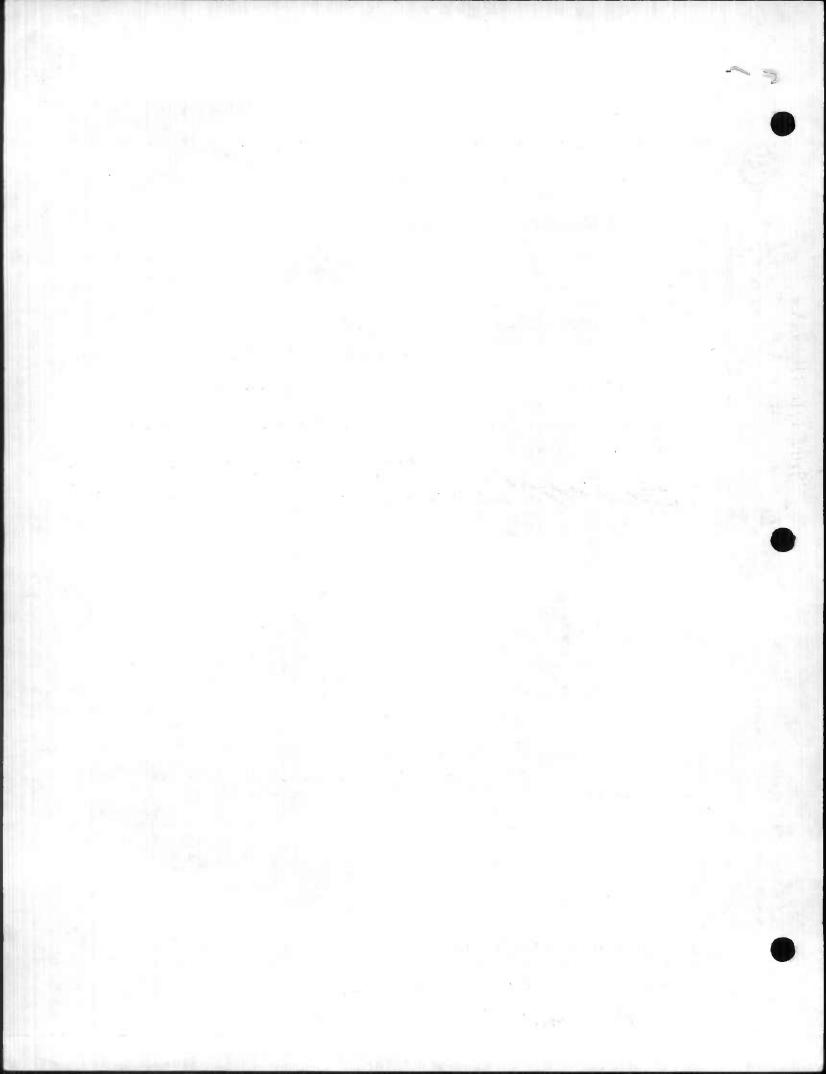
32. Registrar's Signature

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29c. License number



State Registrar Dr. Robert

31. Date filed (Month, Day, Year) FEB 19

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Box 68760,

Vital

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30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

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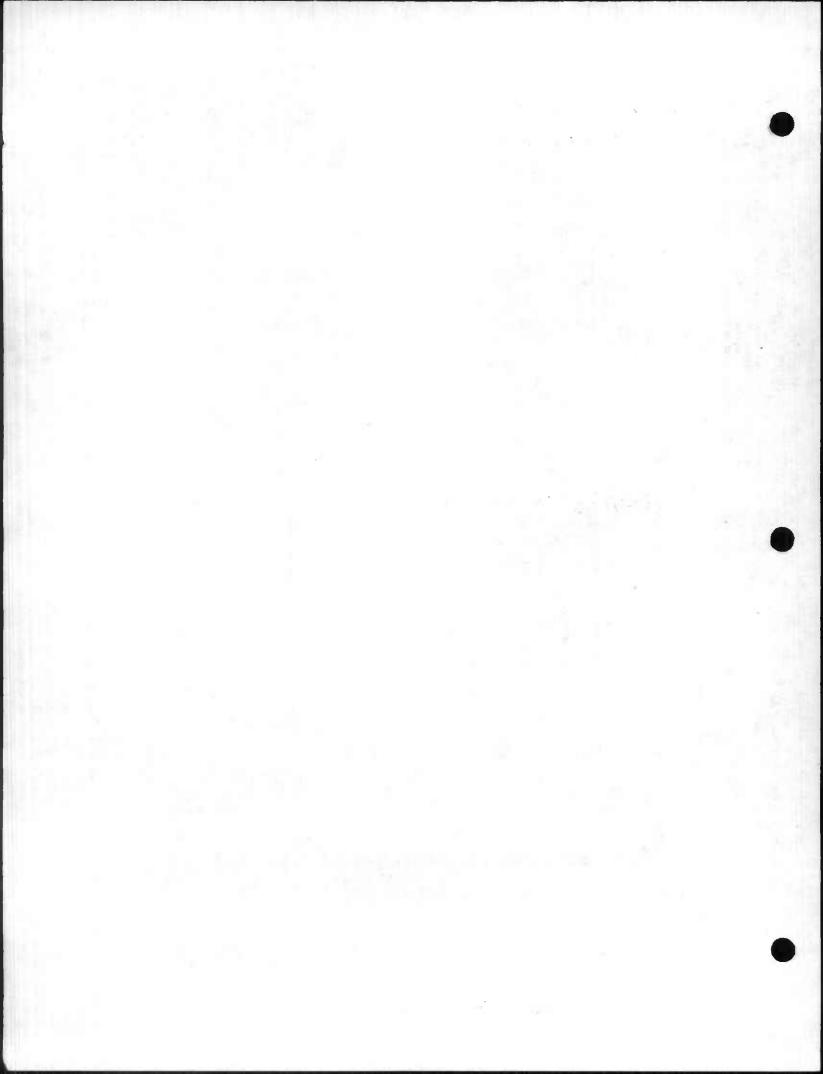
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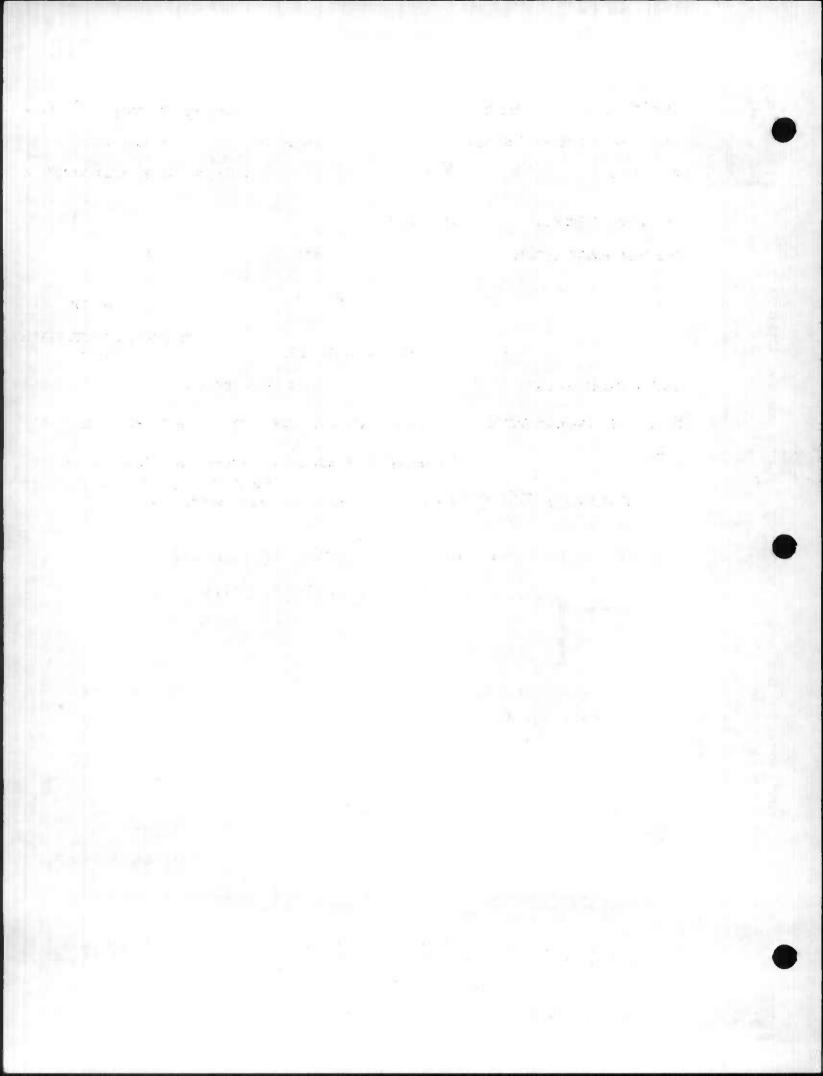
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 0 7 3 1 2

						Cei	tificate of	Death		Reg. No.			
	Dhuninian	1. Decedent's Neme	(First, Middle, Las	st)					2. Dete of De Month	Dey	Yeer	3. Time of	
	Physician /Medical	Marie	May	Shade					Februar		999	8:51	P.M.
	Examiner	4e Fecility Neme (If	not institution, give	e street end number)			4b. City, Town, or	Location of Deet	h 4c. County			
4		FREDERICK	MEMORIA	L HOSPITA	L			FREDERIC	CK	FRED	ERIC	K	
	Funeral	5. Sociel Security Nu			ge (In yrs. I	est birthdey)	If Under 1 Yeer Months Devs			rth W York	9. Birth	plece (Stete o	r Foreign
L	Director	234-01-95 Usuel Residence of I	30	□м 2Д г	8'	Yrs.	Months Deys	s Hours Mil	JULY 2	0, 1914	WES'	plece (State ontry) TVIRG	INIA
	tend wo	10a. Stete	10b. County		10c. City	, Town or Lo	cation		7-11-1	76	1	10d. Inside Ci	ty Limits
	Mary	MARYLAND	FREDERI	CK	FRE	DERICK					418	1 🖾 Yes	2 🗆 No
	# # 150 Dec	10e. Street end Num		O.C	1111	DERLO	10f. Zip Code			10g. Citizen of V	Whet Cour	ntry?	
	death with the Marylend ims 23s or 28s-f show ims the notified at ment be notified at	700 TOLL	HOUSE AV	ENIIE			2	1701		USA			
	ns 2;	11. Maritel Status		12. Wes Deceden	dent Ever in U.S. 13. Was Decedent of				Specify Yes or No		e - Americ	can Indien,	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryler Department of Health and Mental Hygiana. Important: if Item 27 is marked other than "natural", or Items 23a or 23a-f ahow any figury or other treumatic event, the May as Examinat man be notified at once. To Be Completed by Funeral Director	1 □ Never Marrie	_	Armed Forces 1 Yes 2 If Yes, Give Year or Detes	? [No		Yes, specify Cul		rto Rican, etc.)	Specify	ck, White,	etc. HITE	
ö	thurs the		15. Decedent's Ed		16e. Decedent's Usuel Oc (Give kind of work do			pation	16b. Kind of Bu				
15	be filed within 72 ho tal Hygiana. d other than *nature event, the Moules! Be Completed	(Special	y only highest gre	de completed)		(Give	kind of work done	e during most of w	orking	VETERAN			RATIO
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		29a. Certifier	Certifying Ph	ysician: To the best	of my know	vledge, deeth	occurred et the	time, date end pled	ce, end due to the	ceuse(s) end me	enner es :	stated.	
	n 24 hour n 24 hour ne Funer pletaly fill edical	(Check only one)	Medical Exam	ninar: On the basis of end menner s	of examinet teted.	ion end/or In	estigetion, In my	opinion, deeth occ	curred at the time.	, dete and place,	and due t	to the cause(s)
	To the round	29b. Signeture end t	tle of certifier					nse number		29d. Dete signe	d (Month,	Dey, Year)	
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		30. Name end eddre	se of hereon who	completed course of	dooth (Ham	23a) (Tune	Print)	EPEN	2Rece 1	nels the	SC	//	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Leasth Month February Portia A. Saponaro 14, 1999 8:45 A.M. 4a. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Sociel Security Number If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplece (Stete or Foreign Country) Massachusetts 7. Age (In yrs. lest birthday) Deys Hours 1 M 2 KF 92 436-44-7012 Yrs. Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Chevy Chase Montgomery 1 ☐ Yes 2 HNo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8101 Connecticut Avenue 20815 U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2∰No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Nevar Married 2 ☐ Married White 1 ☐ Yes 2 ☒ No Specify: 3 □ Widowed 4 □ Divorced 15. Decedant's Education (Specify only highest grede comp 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry arede completed) Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumema) Peter Donadio Isabella Ierardi 19b. Meiling Address (Streat end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Portia Redfield Daughter 405 East 56th St, New York, NY 10022 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Deta 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gate Of Heaven Cemetery 2/18/99 Silver Spring, MD of Funeral Service Licensee 22. Name and Address of Facility
Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue NW, Washington, D.C. 20016 the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and injure. List only one cause on each line. Approximete Intervel Batween Onset end Deeth Immediete Cause (Finel diseesa or condition rasulting in deeth) Massive Pulmonary Embolism l day Due to (or as a consequenca of) Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings aveilable prior to 24a. Was an eutopsy performed? completion of cause of deeth?

Examiner the buriel-trensit Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseesa or Injury that initiated events rasulting in deeth) Lest Physician/Medicai

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

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Funeral

Director

rsi', or items 23a or 28a-f show Examiner must be notified at

naturs!, or

Pages 1 end 2 should be filed within 72 honent of Heelth and Mentel Hygiene.
int: If item 27 is marked other than "naturity or other traumatic event, in Medical

permit. Page Depertment of Important: If any Injury or

Physician /Medical

Examiner

98 use 0

signed by

page 2 s hes

certificate

After this funeral þ

Completed

Be

Certification: To

Medicai

with the Maryland

death

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Alzheimer's Dementia

28a. Dete of Injury (Month, Dey Year)

Chronic Obsturctive Lung Disease

25. Wes case referred to medical

1 Yes 2 No 27. Menner of Death

5 Panding Investigation 1 Maturel 2 Accident 3 Suicide 4 Homicide

6 Could not be detarmined

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c, Injury at Work? 1 ☐ Yes 2 ☐ No

28. Place of Deeth (Check only one)

 Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end menner steted.

1 Yes 2 No

28d. Describe how Injury occurred

me of certifier 29b, Signature

29a. Certifier

29c. License number

29d. Dete signed (Month, Dey, Year) February 16, 1999

1 ☐ Yes 2 ☐ No

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Mark H. Eig, M.D. 10801 Drive, Silver Spring, MD 20901

State Registrar

31. Dete filed (Month, Day, Year) FEB 2 2 1999 32. Registrer's Signeture

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D24886

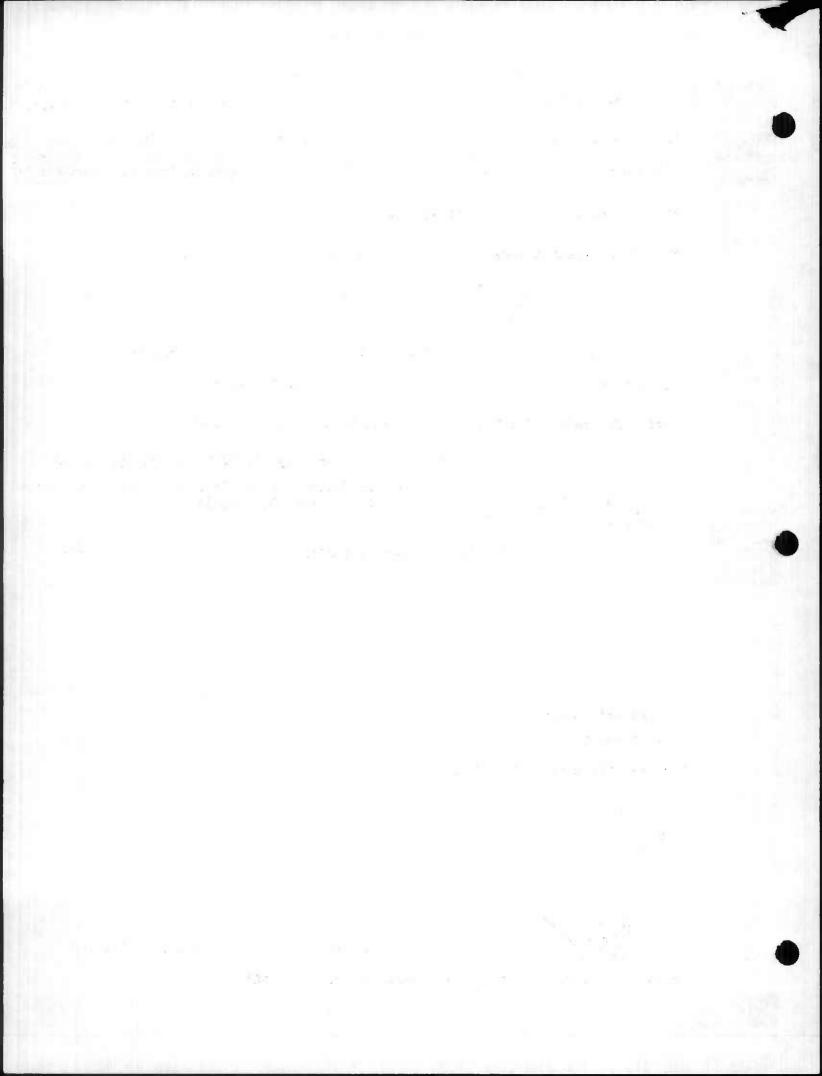
DHMH 16 Rev 6/95

The law requires that the death certificete be executed P.O. Box 68760. Records. of Vital

Division

Hospital or Attending Physician: s efter deeth. filled in by the To the Hospital within 24 hours e

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be nettified at once.
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FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN CERTIFICATE OF DEATH REG. NO.	E				

	REGISTRAR	CERTIFIC	ATE OF DE	ATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				DATE OF DEATH		3. TIME OF DEATH
	Levi H. Stanle				72 /	7 9	9 8 45 A"
				DER 24 HRS. 7, C	DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	218-16-5743 1XM20F 7	76 YRS.	NTHS DAYS HOUR	IS MIN.	7 /2 Z	1 :	Mary/and
	9e. FACILITY NAME (If not institution, give street end number)		. CITY, TOWN OR LOC	ATION OF DEATH	7 7 22 2		Y OF DEATH
E C	Mallard Bay Nursing Home		Cambridge			Dorot	nester
5	RESIDENCE OF DECEDENT		cambilage			DOLCI	lester
DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY, T	OWN OR LOCATION				10d. INSIDE CITY
ā	Maryland Dorchester	Camb	ridge				1X YES 2 NO
AL	10e. STREET AND NUMBER		10f. ZIP C	ODE		10g. CITIZE	N OF WHAT COUNTRY?
E	701 Race Street		2161	3		USA	
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER I 1 □ Never Merried 2 ★ Married FORCES? 1 □ YES	IN U.S. ABMED	13. WAS DECENDEN	T OF HISPANIC O	RIGIN? (Specify Yes		I. RACE — American Indian,
ВУ Е	1 Never Married 2 Married FORCES? 1 YES 3 Wildowed 4 Divorced IF YES, GIVE WAR OR D	DATES	1 Yes, specify Co	uben, Mexican, Pu NO Specify:	erto Rican, atc.)	1	Black, White, etc. Specify:
8	3 Widowed 4 Divorced						Black
Ē	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US	UAL OCCUPATION done during most of wo	orkina	16b, KIND OF BUS	INESS/INDUS	STRY
Ë	Elementary/Secondary (0-12) College (1-4 or 5+)		•				
COMPLETED	3	Load	er		Seafood	l Fac	tory
8	17. FATHER'S NAME (First, Middle, Last)		18. M	OTHER'S NAME (F	irst, Middle, Meiden	Surname)	
BE	William Han				Lee	Nich	
6	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING AD	DRESS (Street and Num	aber or Rural Route	Number, City or Town	, State, Zip Co	ode)
-	Levi Stanley	4819 Sk	ee Club R	d.,P.0.1	BOx938, H	urlock	,Md.21643
	20e, METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Removal from State CH	b. PLACE AND DATE OF C	ISPOSITION (Name of		DATE 20c. LOC	CATION - CIT	y or Town, State
	4 □ Donation 5 □ Other (Specify) M	netery crematory or other t.Pleasant	Cemetery	2,	/22/99 Sa	alem, M	laryland
	21. SIGNATURE OF FUNERAL SERVICE CICENSEE		Bennie Si	RESS OF FACILITY	Υ		
							21.601
	23. PART I. Enter the diseases, or complications that cause	d the deeth. Do not	P.O.Box	dving such as	eston, Mai	ryland	21601
	snock, or hasn tsilure. List only one cause on e	ach lina.		aying, such ss	cardiac or respir	atory arres	intarval Between
	IMMEDIATE CAUSE (Fine) disease or condition	110 111	aloren				Onset and Death
- 1	resulting in death) s.	ple My a consequence of: Meta	Comme				340
_	Bosse	Man L	1				
CERTIFICATION	Sequantistry list conditions,	A CONSEQUENCE OF:	71				6 mas
¥	if sny, leeding to immediate cause. Enter UNDERLYING						i l
띹	CAUSE (Disease or injury that initiated events DUE TO (OR AS A	A CONSEQUENCE OF):					
E	resulting in death) LAST						
EDICAL	PART II. Other significant conditions contributing to death be	out not resulting in t	he underlying ceus	e given in Part	i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
8					1 TYES 2		COMPLETION OF CAUSE OF GEATH?
ME							1 YES 2 - 1040
1	DID TOBACCO USE CONTRIBUTE TO CAUSE C	OF DEATH YES	□ NO □ UN	ICERTAIN [ונ		
ĕ.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)				
PHYSICIAN	1 YES 2. NO 1 Inpatient 2 ER/Out		THER: Nursing Home 5 🗆	Residence 6 🗆	Other (Specify)		
춪	27. MANNER OF OEATH 26s. OATE OF INJURY	28b. TIME O	F 28c. INJURY AT		DESCRIBE HOW IN	JURY OCCUR	RED
BY F	Natural 5 Pending (Month, Day, Year) 2 Accident investigation	กลบบท	M 1 YES 2	2 NO			
0 8	3 Suicide 26s. PLACE OF INJURY	/ — At home, ferm, atree	et, factory, office	28f.	LOCATION (Street e	nd Number or	Rural Route Number,
ш	4 Homicide determined building, etc. (Spe	any)			City or Town, State)		
COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my know	ladge death possessed a	t the time determined at				
N N	(Check only one) 2 MEDICAL EXAMINER: On the best of examination						
	295. SIGNATURE AND TITLE OF CERTIFIER,				outs end piacs, end		
ᆱ	THE AND TITLE OF CERTIFIER		29c. L	JCENSE NUMBER		29d. DATE S	IGNED (Month, Day, Year)
9	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE			11541	`	d	11/199
	1/:	AIH (ITEM 27) (Type, Prin	11)				
	31 DATE EIL ED Alborth Day Mari	Tupes	2 45 and	dans	16 am	613	
	31. DATE FILED (Month Pay, 16er) 1999 32. REGISTRAR'S SIGN		ports				
		1	pour				

1.1763

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month February **Physician** ľ8, 1999 Sabiha 1:07 AM Sani /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Deys 1□ M 2♥ F Yrs. 42 July 24, 1956 216-49-1453 Bosnia Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐ No Maryland notifie Directo Prince George's Laurel 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? or liens 23s or aminer must be 8800 Barnsley Court, #33 20708 Bosnia Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after of not Mental Hygiene. marked other than "natural", or liter armatic event, the Medical Examiner. 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Clerk Public Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H anti: If them 27 is marked oth jury or other traumatic even Be Kasim Sarvan Mina Ajkunic 19e. Informent's Name/Retationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Adam Sani (husband) 8800 Barnsley Court, #33, Laurel, Maryland 20708 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c Location - City or Town State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or Chesapeake Crematory 2-22-99 Beltsville, Maryland 21. Signeture of Funeral Service Licenses 22, Name and Address of Facility
Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finet Septic Shock 1 Week disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner 1 Month Rectal Cancer ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Due to (or es e consequence ot): physician s the burial P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 40 been signed by the s should be deteched i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Pancytopenia þ Records. Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy Respiratory Failure completion of cause of death? page 2 1 ☐ Yes 2 ZXNo 1 No 2 No certificate Division of Vitai or Attending Physician: funaral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? After 5 Pending 1 Neturet death. 1 Yes 2 No investigation Ne Hospital or Attendi In 24 hours after death. Ne Funeral Director: A 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 3 4 Homicide filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

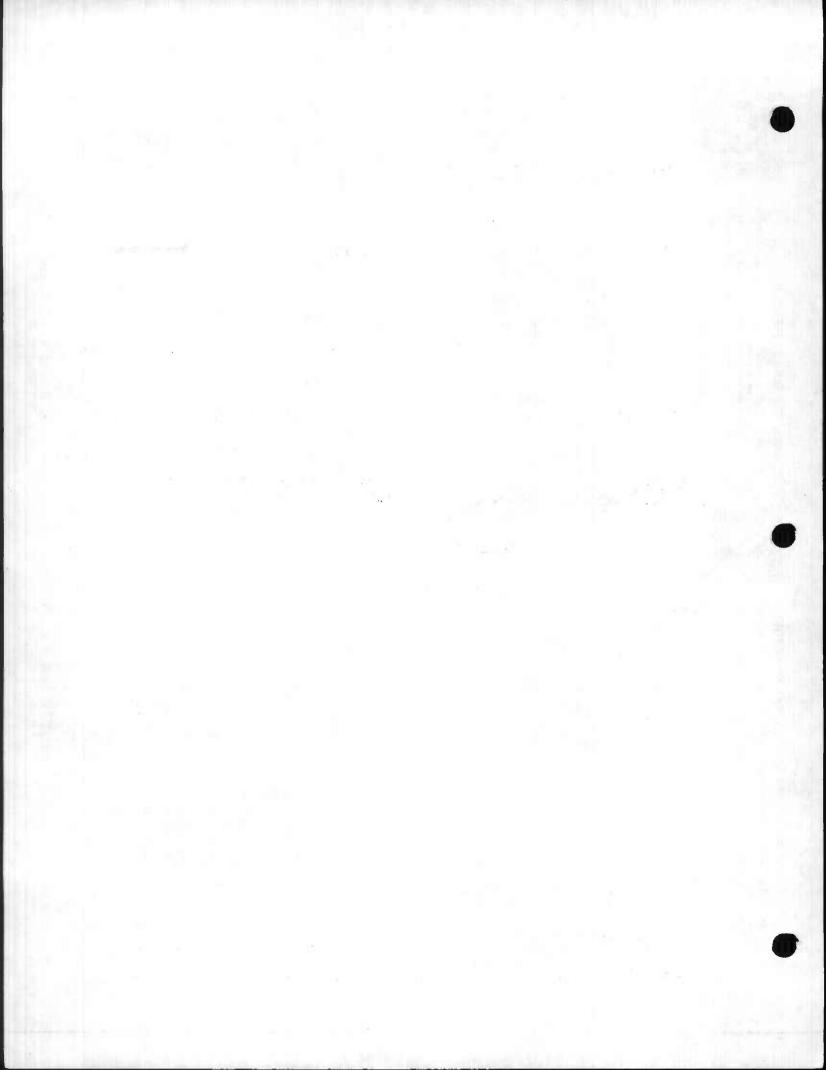
| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and menner stated. 29a. Cartifier edical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier, seler - mo 0-21910 30 Nama and address of person who completed cause of death (Item 23a) (Type, Print) wheaton Sherer mp 209060 3947 mo terrara 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

DHMH 16 Rev 6/95

State

Registrar

FEB 22



State of Maryland / Department of Health and Mental Hygiene 07316

							Ce	ertificat	e of	Death		Reg. No	99	U	1010
	Physic /Medi		1. Decedent's Neme (F	îrst, Middle, Li	Ronale	d Cole	man S	Sharp			2. Date of D Month Februa	eath De		Year 999	3. Time of Death 4:45 PM
	Exami	- 1	4e Facility Name (If no	t institution, gi	ve street and nu	mber)				4b. City, Town, or L	ocation of Dea	-	. County		
			Holy Cross	Hospi	tal				1	Silver Sp	ring	Mo	ntgo	mery	
	Funeral Director		5. Social Security Numb 220-26-704		Sex 1☐M 2☐ F	7. Age (In yrs. 66	last birthday Yrs.	Months	r 1 Year		8. Date of B. (Month, D. July 1	irth Day, Year	932	Cour	place (Stete or Foreign htry) York
	P .		Usual Residence of Dec			10.00	-								
	the Marylar 28a-f show roth of it	Director	Maryland M	b. County	ery		y.Town or L Ver S							1	1 ☐ Yes 2 ☑ No
	0 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Sire	10e. Street and Number	r				10f. Zip	Code			10g. Ci	tizen of W	Vhat Cour	ntry?
	th w	a	3406 Farth	ing Dr	ive	20906						Uni	ted	State	es
020	72 hours after deeth with the Maryland natural, or items 23s or 28s-f show	by Funeral	11. Meritel Stetus 1 Never Merried 3 Widowed 4		Armed Fo	2 No		. Was Dece If Yes, spe 1 Yes		dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	lo-		k, White,	
2-0	n 72 hours natural'	D D		Decedent's E	ducation ade completed)		16a. Dec	edent's Usu	el Occup	pation	rina	16b. K	(ind of Bu	siness/In	dustry
2121	d within piene. r than	Completed	Elementery/Seconder	1	Coilege (1	I-4or 5+)		Sale		during most of work d) 1	ang	Pri	vate	Sto	re
Maryland 21215-0020	s 1 and 2 should be filed I Health and Mental Hygis tem 27 is marked other other trsumatic avent, II	To Be C	17. Fether's Neme (Firs		1)					18. Mother's Nem Myrtle		e, Maider	n Sumam	ө)	
ary	and Name		19e. tnforment's Neme	_	(Type, Print)		19b. Mei	ling Address	s (Street	end Number or Rui		ber, City	or Town,	State, Zip	Code)
	alth al 27 la pr treu		Ann H. Sh	arp	7)	wife)	San	ne as	10						
Baltimore,	6 D		20e. Method of Disposit 1 Buriel 2 XC 4 Donetion 5	remetion 3 [State	Plece of Disp semetery, criteria				Dete				Maryland
Balti	permit. Page Department in Important: If any Injury or ence.	any injur	21. Signeture of Funere		and the same	20	F	22. Neme er Rapp F	nd Addre	ess of Facility ral Service avenue, Si	ces, P.	Α.			
	Physician		23a. Part1. Enter the d shock, or heert fel	iseese, or con iture. List only	nplicetions that c	aused the deetl	h. Do not e	nter the mod	de of dyi	ng, such es cardiec	or respiretory	errest,	g, m	20	Approximete Intervel Between Onset and Death
	/Medical Examiner		Immediete Cause (Fina diseese or condition resulting in deeth)	al	Pulmonary Embolism								1	Sudden	
		ē			Door	,	ras a cons		:						1 77 1
	and transit	Examiner	Sequentially list condition	ons,	b. Deep Vein Thrombosis Due to (or es a consequence of):									1	1 Week
68760,	be ax		Sequentially list conditlif eny, leeding to immediates. Enter Underlyin Cause (Diseese or injurthat initiated events	ng ry	C									-	
Box 687	eath certificate be assecuted attending physician and for use as the burial-transit	in/Medical	resulting in death) Last	ι	d	Due to (o	r es a conse	equence or):							
	the atter	Physician/M	Pert II. Other algnifican	t conditions	contributing to de	eath but not resi	ulting in the	underlying o	cause gi	ven in Pert f.	23b. Did	d tobacco	o use cor	ntribute t	o the cause of death
s, P.O	ires that the designed by the	by Phy	Chronic O	bstruc	tive Pul	lmonary	Disea	ase			10	Yea 2	2□ No	3 ☐ Pro	bably 4 M Unknow
ecords	aw requisite been 2 should	Completed I										performed? ave			fere autopsy findings reilable prior to empletion of cause death?
Œ	E se	Con									11	Yes 2	No	1[☐ Yes 25 No
of Vital		Be	25. Was case referred to examiner?	to medicai	26. Place of Deeth (Check only one)										
of \	Physician: this certific ral director,	2	1 ☐ Yes 2 🗓 No								ome 5 Residence 6 Other (Specify)				
ion	th. : After the funera	ation:	27. Menner of Deeth 1 ☑Neturel 5 2 ☐ Accident	☐ Pending investigetic		of Injury th, Dey Year)	28b. Time Injury	of M	28c. tnju Wo 1 🗀	ry at rk? IYes 2 □ No	28d. Describe	a how inju	iry occurr	ed	

To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After completely filled in by the funer Medical Certificatio

29a. Certifier (Check only one) 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner steted. 29b. Signeture and title di certifier

6 Could not be determined

2 Accident

3 Suicide

4 Homicide

29c. License number D 32332

29d. Date signed (Month, Day, Year) February 24, 1999

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

S. K. Gupta, M. D., 9801 Georgia Avenue, #220, Silver Spring, MD 20902 31. Date filed (Month, Dey, Year)

State Registrar

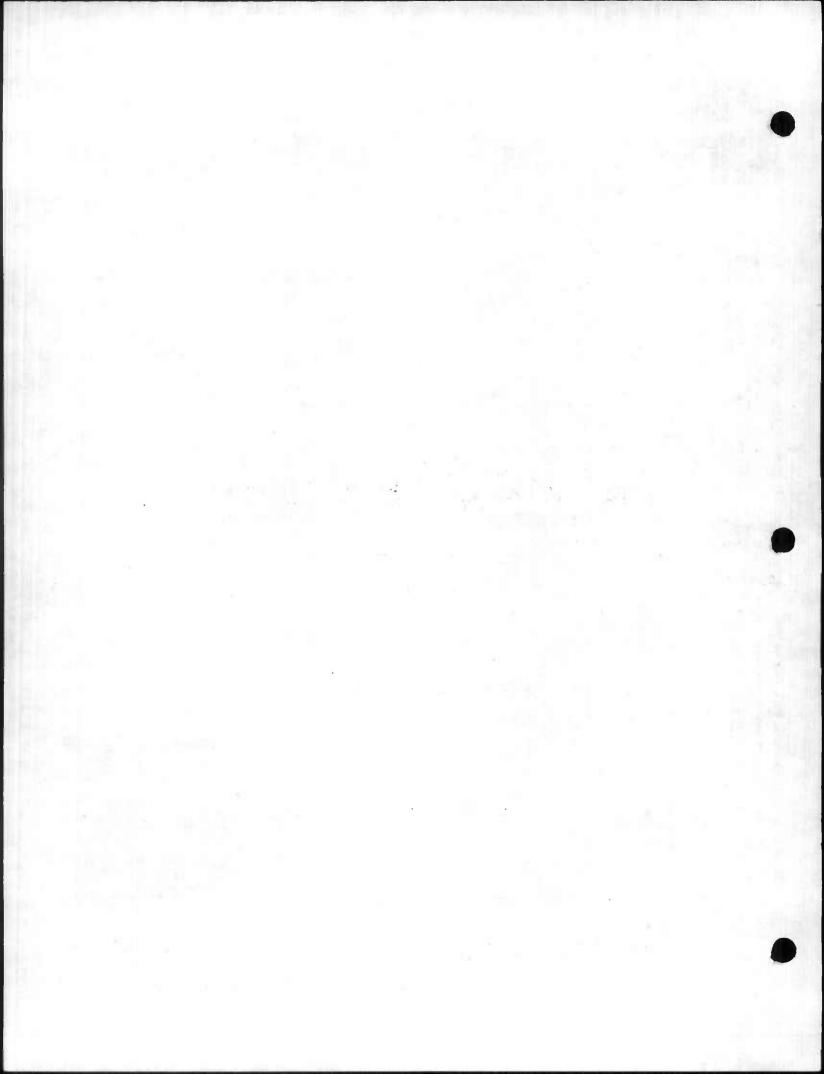
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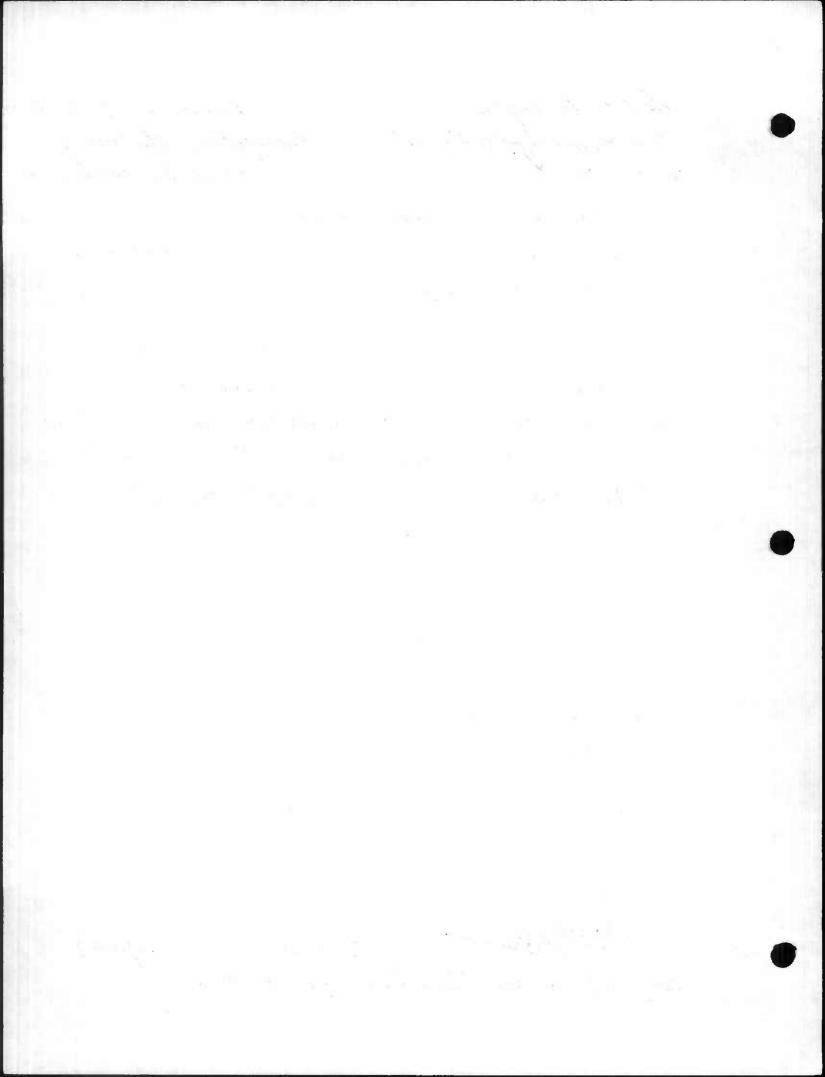
32. Registrar's Signeture

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95



be filed within 72 hours effer death with the Manyland lat Hyglene. I dether then "natural", or items 23s or 28s-f show wont, its Medical Examiner must be notified as word, its Medical Examiner must be notified as word, its Medical Examiner must be notified as word, its Medical Examiner must be notified as word and its medical Examiner must be notified as word and its medical Examiner must be notified as word and its medical Examiner must be not set of the notified as well as word and its medical examiner must be not set of the notified as well as wel	5. Soofai Security Number 0/4-/2-2543 Usual Rasidance of Dacedant 10a. Stata 10b. County	gomery 12. Was Decedant Armed Forcas? 1 Mas 2 I I Mas 2 I I I Mas 2 I I I Mas a condition of the second of the s	Evar in U,S.	r Location gomery V	Days Hours Min.	8. Data of Bin (Month, Da Nov. 6	Day 18 4c. County 19 19 10 10 10 10 10 10 10 10	Year 1999 of Death 1 country Massac	a (Mata or Foraign Chusetts Insida City Limits
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filed with Hygiene. wher then ent, fre M		Coilega (1-4or 5	(G		Occupation dona during most of work retired) ministrator	ing	Federal Gover		ry
Sa Sa Sa	17. Fathar's Nama (First, Middia, L Michael J. She				18. Mothar's Name	a (First, Middla, ne O'Ma)		18)	
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C T N &	Mary D. Shea	(Wife)			tfield Ct. 1				
Peges nent of nut: If It ury or o	20a. Mathod of Disposition 1 ☐ Burial 2 ☼ Cramation 4 ☐ Donation 5 ☐ Othar (Sp			isposition (Nama cramatory or oth olitan	arplace) Crematory	eb. 19,	Alexano		
permit. Peg Depertment Important: I any Injury o once.	21. Signature of Funaral Sarvice L	Lay,			Addrass of Facility De Deer Park		eral Hor thersbur		20877
death certificate be executed to a stending physician and did for use as the burial-transit of iclaryMedical Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Infect	Dua to (or as a con Dua to (or as a con Dua to (or as a con	oCARDIZ saquance of):	lis				
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235	PROCAINE ADRE	lic Valve					an autopsy rmed?	availat	autopsy findings bla prior to etlon of cause th?
Com						101	as 20 No	1 □ Ya	as 2 No
certificate rector, pag	25. Was casa rafarred to medical axaminar?	Hospital:			26. Place of Deat	h (Check only o	na)		
F SE P	1 Yas 2 No 27. Manne of Death 1 Natural 5 Pending	1 ∐ Inpatia 28a. Data of Injui (Month, Day	y 28b. Tim		4 Nursing Ho		lance 8 Oth		
the eat	2 Accident Invastige 3 Suicida 6 Could no 4 Homicida determin	ot be On Dines of lais	ury - At homa, farm, c. (Specify)			28f. Location (5 City or Tox	Street and Numb m, Stata)	er or Rural Ro	uta Number,
To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by Medical Certiff	29a. Certifiar (Check only one)	Physician: To the best of taminar: On the basis of and mannar sta	examinetion and/or	aath occurred at r invastigation, in	the time, data and plece, my opinion, daath occur	and dua to the ded at the time,	cause(s) and ma data and placa,	anner as stated and dua to tha	t. cause(s)
within 3	29b. Signature and title of Enrillied	and.	_	29c. L	icansa number		29d. Data signed	d (Month, Day	, Year)
XX (4)	30. Name and address of person w	who completed cause of de	eath (Itam 22a) (T.	D Print)	053691		2/18	/199	9
, ,	31. Date filed (Month), Pay, Yaar)	3 3000 Mg	ar's Signatura	IVENUE,	Kensington	, MD 2	0895		



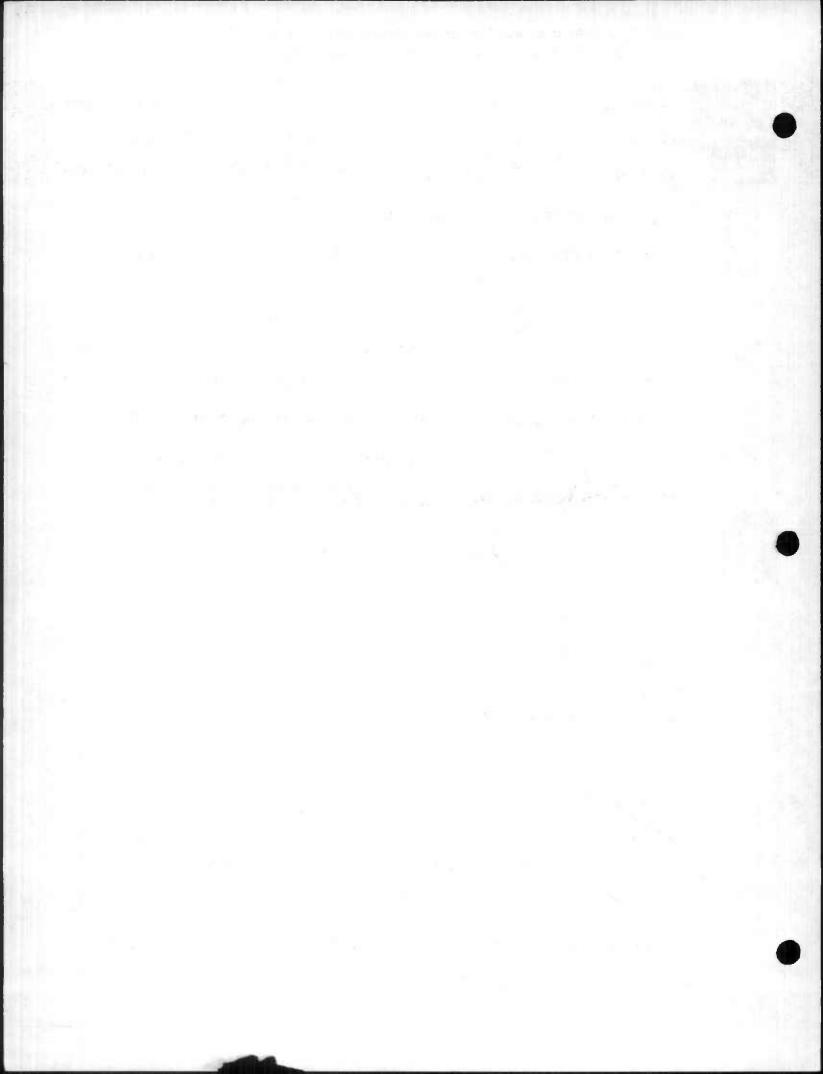
State of Maryland / Department of Health and Mental Hygiene 99 073 | 8 Certificate of Death

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	Physic /Medi		1. Decedent's Nan GERTRU	ne <i>(First, Middle, La</i> DE		HEPARD					7	2. Dete of De Month FEB.	Day 22, Day	Yeer	3. Time of the th
	Exami			(If not Institution, giv RE CHEVY		ber)				4b. City, To		cation of Dee		of Deeth	RY
	Funeral Director		5. Sociel Security 345-20-4	907	Sex I□M 2ÅF	7. Age (In yrs. 85	lest birthday) Yrs.	If Under	or 1 Year Deys		24 Hrs. Min.	8. Date of Bi Allonth, D APR.	rth Year) 913	9. Birthp	plece (State or Forei
	the Meryland 28a-f show	_	10e. State	10b. County	DV		ly, Town or Lo							1	10d. Inside City Limit
	e Me	cto	MD	MONTGOME	KI	CHI	EVY CHA	SE							1 □ Yes 24 N
	or 2	Dire	10e. Street end Nu						ip Code				10g. Citizen of		ntry?
	ath w	<u>a</u>	8700 J	ONES MILL	ROAD				815				US		
020	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Nems 23s or 28s-f show int, the Modical Examinet must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Mar 3 ☒ Widowed	ried 2 Married	12. Wes Deced Armed Ford 1 Tes 2 If Yes, Give Yeer or Dat	es? No		Was Dece 1 Yes, spo 1 🗆 Yes				ecify Yes or N Rican, etc.)	Specif	ck, White,	
5-0	72 hc	ted	(Sne	15. Decedent's Ed	ducation		16a. Deced	dent's Usi	uel Occu	pation during mos	et of work	ina	16b. Kind of B	usiness/in	dustry
21215-0020	d within giene. or than "	Completed	Elementery/Sec 12		College (1-4	4or 5+)	SECRE	DO NOT	use retire	ed)	n or work	ng	ADMIN	ISTR	ATOR
Maryland	ed in b	To Be (17. Fether's Neme PHILIP	(First, Middle, Last)						18. Motho		(First, Middle KARPE	, Maiden Surner N	ne)	
	nd 2 offith el 27 is r treu			lame/Relationship (ER							NG, MD 2		Code)
Baltimore,	00-7			sposition Gremation 3 5 5 Gother Specific		tate	Pleca of Dispo Semetery, crem NORAH (netory or	other ple	ace)	2	Dete /24/99	W. PALM		
Balt	permit. Peg Department Important: I any Injury o		21. Signeture of F	uneral Service Licer	len	٥	DA	NZAN	ISKY-	ess of Fecili	BERG	MEMORI ROCKV	AL CHAPE	ELS II	NC.
	Physician /Medical Examiner		23a. Pert 1. Enter shock, or be Immediate Ceuse disease or conditi- resulting in deeth)	on		Izhei		or the mo	nde of dy	ing, such es					Approximate Interval Between Onset and Death
ox 68760,	h certificate be axecuted ending physician and usa as the burial-frensit	an/Medical Examiner	Sequentially list or if eny, leading to it cause. Enter Und Cause (Disease o that initiated event resulting in deeth)	S	b. — — — — — — — — — — — — — — — — — — —		or es e conseq or es e conseq	_							
m	death e atte		Pert II. Other eigni	ficant conditions o	ontributing to dee	th but not resi	ulting in the ur	nderlying	CAUSA (I	iven in Pert i		23h Did	tohacco usa co	ntribute to	o the causa of deati
s, P.O	res that the de signed by the a be detached f	by Physici		- Lamph				Toonying	00030 g				Yes 2/2 No		bebly 4 Unkno
Division of Vital Records,	aw requi	Completed t			_								en eutopsy ormed?	ev	ere eutopsy findings reileble prior to empletion of cause deeth?
æ	The law ata has page 2	E O										10	Yes 2 No	10	☐ Yes 2☐ No
Ita		Be (25. Wes case refe exeminer?	rred to medical						26. Place	e of Deeth	(Check only	one)		
>	2 00	2		No	Hospitel: 1 In	patient 2 🗆	ER/Outpetien	t 3 D	OA OI	her: No	ursing Ho	me 5□Res	idenca 6 □Oth	ner (Specif	(y)
sion c	il or Attending Ph after death. I Director: After thi d in by the funeral	ation:	27. Menner of Dee 1 ☑ Neturel 2 ☐ Accident	5 Pending Investigation		Injury Dey Year)	28b. Time of Injury	М	28c. Inju Wo 1	ıryat ork?]Yes 2 ☐		28d. Describe	how injury occur	red	
Divis	tal or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zoe. Placa o	f Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, stre y)	eet, facto	ry, office				Street and Numl wn, State)	ber or Rure	el Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire complataly filled in b	edicai	29a. Certifier (Check only one)	Certifying Phy 2 Madical Exem	ysicien: To the b niner: On the bas and manne	is of examine	wledge, death tion end/or inv	occurred estigetion	d et the t n, in my	ime, dete en opinion, dee	d plece, o	end due to the ed et the time,	ceuse(s) end mo date end pleca,	enner es s end due to	teted. o the cause(s)
	To the To the Common	Σ	29b. Signeture and	dittle of certifier	Poth m	5-				se number 2309	3		29d. Date signed Feb - 2		
			Phillip W	ress of person who	completed cause	of deeth (item			ier :	Sprins,	Ma	209	01		
	Sta	ite	31. Dete filed (Mor	oth, Day, Year)	32. Reg	gistrer's Signe	ture								

State Registrar

FEB 25 1999





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month February Leon Max Shock 19, 1999 2:55 PM 4a Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Undar 24 Hrs. If Under 1 Year Birthplece (State or Foraign Country) 5. Social Security Number 7. Aga (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 100 M 20 F Months Deys Hours 579-16-4419 78 Yrs. Mar. 9, 1920 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County MD 1 Yas 2 No Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 9313 Avenel Road 20903 USA 14. Race - American Indian, 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritel Status Bleck, Whita, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Never Merried 2 Married 1 Yes 20 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Spacify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Retail 18 Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Max Shock Lena Stoklisky 19e. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Ruth G. Shock/Wife 9313 Avenel Road, Silver Spring, MD 20903 20b. Plece of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremation 3 Removal from State Donetion 5 Other (Specify) Judean Memorial Gardens 2/21/99 Olney, MD 22. Name and Address of Facility Takoma Funeral Home 21. Signature of Funeral Service Licansee 254 Carroll St. NW, Washington, DC 20012 23a. Pert1. Enter/ha diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or raspiretory errest shock, or heart tellure. List only one cause on each line. Approximate intervel Between Onset and Death Immediate Ceuse (Finel Stroke days diseese or condition resulting in death) Due to (or as a consequence of): tibullu Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 □ Probably 4 Nunknown 1 Yes 2 No 24b. Were eutopsy tindings eveileble prior to 24a. Wes an autopsy completion of ceuse of deeth? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese reterred to medice exeminer? 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined

physician end the bunal-transit for use es 98 signed by the ed page 2 hes certificate director, this funeral After after death. Director: Aft

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at

permit. Peges 1 end 2 should be filed within 72 hours efter deeth. Department of Heelith end Mental Hygiene. Important: If flem 27 is marked other than "natural", or frems 23s any Injury or other traumstic avent.

Physician /Medical

Examiner

Examiner

Physician/Medicai

þ

Completed

10

Certification:

Medical

3 Sulcide

29e. Certifier

4 Homicide

29b. Signature and title of cartifiar

Baltimore, Maryland 21215-0020

with the Merylence

/Medical

Director

Funeral

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Completed

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours a To the Hosp within 24 hor To the Fune completely fi

> State Registrar

Gravino, MD

28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify)

29c. License number

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated.

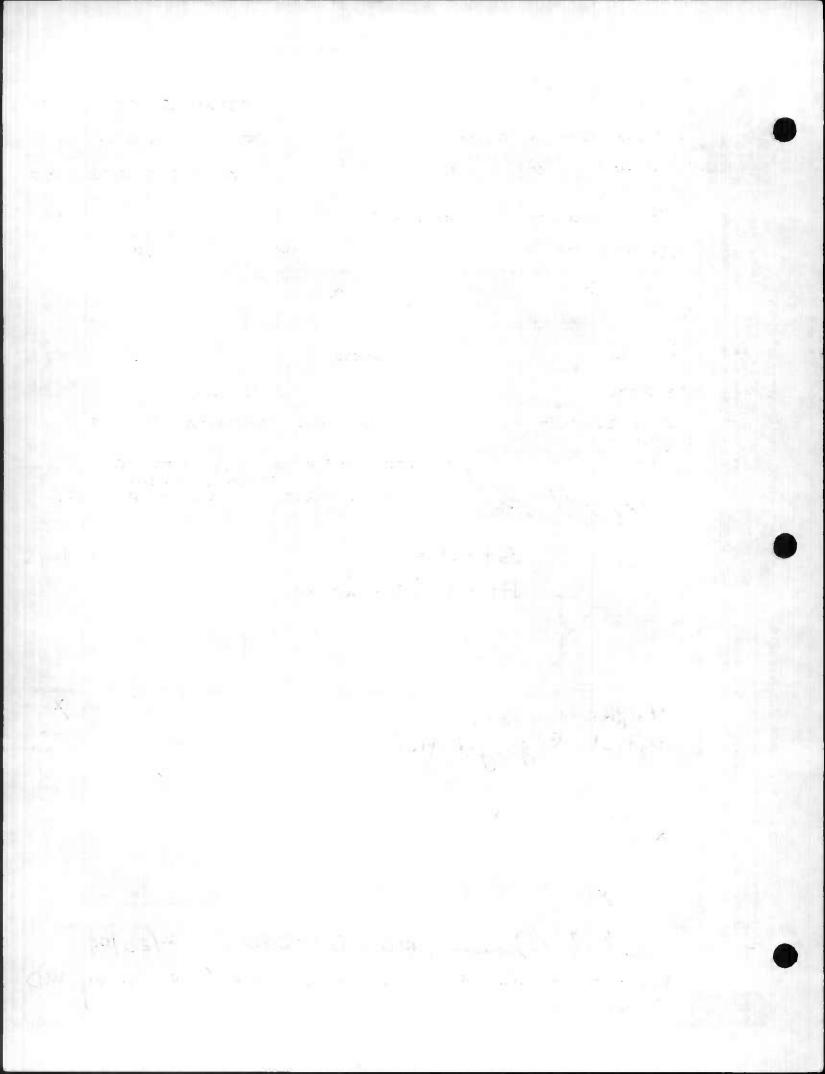
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

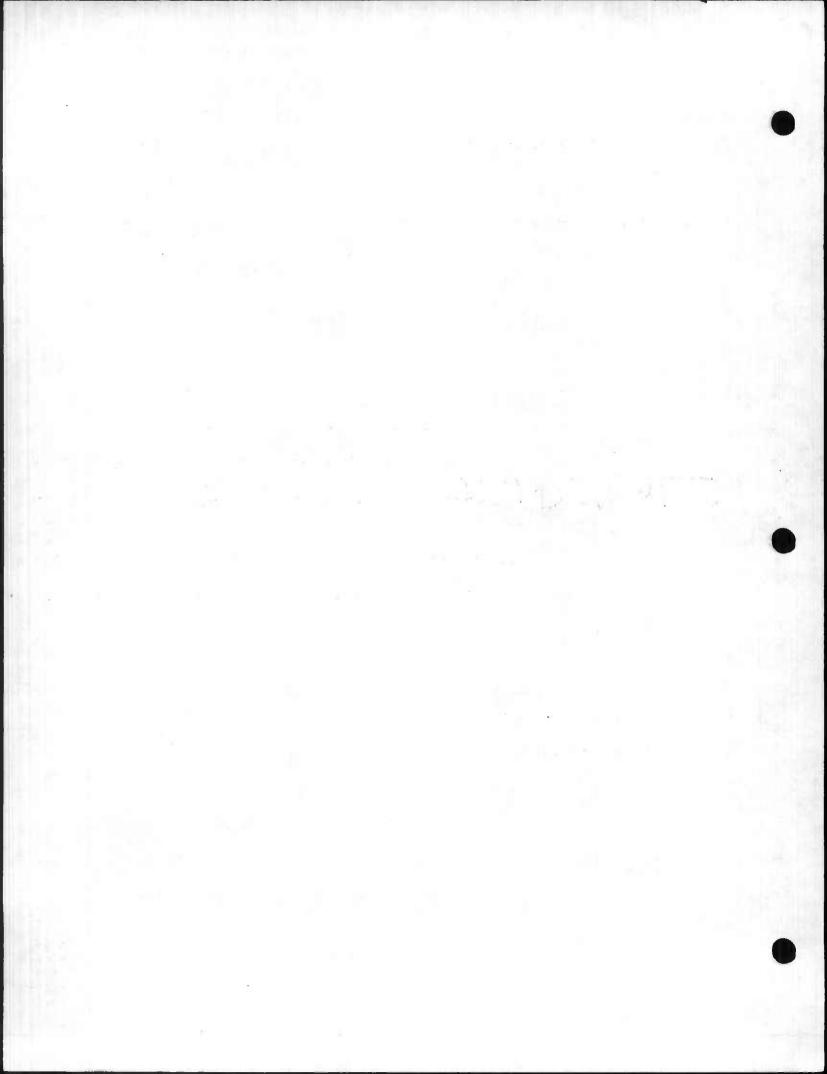
10313 Georgia Ave, Silver Spring



State of Maryland / Department of Health and Mental Hygiene 9 9 7320

			(Certifica	te of De	eath	Be	g. No.	010	6. 0
	1. Decedant's Nama (First, Middla, Las)					2. Data of Deat	1		Time of Death
Physician	Minnie	Mae S	igl				Month		Year	:22 AM
/Medical Examiner	4a Facility Name (If not institution, give		-8-		4b. 0	City, Town, or L	ocation of Death	4c. County		• 22 Au
2201111101	SHADY GROVE		HOCDI	- m 3 - T		DOGWIY		MONT	mcown:	227
Funeral	5. Social Security Number 6. Se	ADVENTIST 7. Aga (In yrs. last birth	day) If Unde		ROCKY.			TGOMEI 9. Birthpiaca (Country)	
Director	271-22-6125	DM 2∰ F	87 Y	rs. Months	Days	lours Min.	(Month, Day, Feb. 21		Arkans	
_	Usual Rasidence of Decedent		- 07	_ 1			1100. 21	, 1)11	nikans	540
80 11	10a. Stata 10b. County	1	Oc. City, Town	or Location				10d. Inside City		
when 72 nous arter oearn with the maryland than "natural", or items 23a or 28a-f ahow ha Medical Examinar must be notified at pmpleted by Funeral Director	Maryland Montgon	larv	Boyd	l c				1 ☐ Yes 2I		
284	10e. Street and Number	icry	воус		p Code		10	g. Citizen of W	hat Country?	
0 0	21001 Bubs Duiss				00/.1			TT - * 4	1 04 - 4	
r frams 23a or 28a-fa diner must be notified Funeral Director	21901 Ruby Drive	12. Was Decedent Eve	ar in U.S.		0841	nic Origin? (Sc	necity Yas or No-		d State	
4 P	1 □ Never Merried 2 □ Merried	Armed Forcas? 1 ☐ Yes 2 ☑ No		If Yes, spe	city Cuban, i	Jexican, Puerto	pecify Yas or No- Rican, atc.)		, Whita, atc.	
by F	3 Widowed 4 □ Divorced	If Yas, Giva Yaar or Datas:		1 Yas	21 No 5	pecify:		Specify:		
De la	15. Decedent's Edu	The sections	160 0	Decedent's Usu	al Cooupatio		1.	6b. Kind of But	White	5
et de	(Specify only highast grad	le completed)	(Giva kind of wi	ork dona duri	ng most of worl	king	OD. KING OF BU	sinassinoustry	
then the	Elementary/Secondary (0-12)	College (1-4or 5+)						II am		
nd Mental Hygiene. marked other than "natura umatic avent, tha Madical." To Be Completed	17. Fathar's Name (First, Middle, Last)			Homem	- 1	Mother's Nam	na (First, Middla, N	Hom		
to Chealth and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic avent, tha Medical Examinar must be notified at or other traumatic avent, that Medical Examinar must be notified at or other traumatic avent, that Medical Examinar must be notified at other and the contract of the	Tr. Caulai S Ivanie (First, Micole, Last)				18	. WOTHER S NEIT	ia (r.1131, Milliali, N	Liver Sumame	-/	
Menter de la constante de la c	Unknown						Gertru	-	lone	
le ma	19a. Informant's Name/Relationship (T)	ype, Print)	19b. i	Mailing Addres	s (Street and	Number or Ru	ral Routa Number,	City or Town,	Stata, Zip Code)
Health em 27 rther tr	Sandra Haba/Daug	hter	219	08 Rub	y Driv	e, Boyd	s, Maryl	and 208	41	
of He of He	20a. Mathod of Disposition		20b. Plece of D	Disposition (Na crematory or	ma of other place)		Data	Oc. Location - 0	City or Town, S	tata
H H	1 ☐ Burial 2. ☐ Cramation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify)		Metropo			ory 2	/21/99 A	1 evendr	ia Via	cainis
ortant: injury	21-Signature of Funerill Service Licens		-		nd Addrass o	A Charles				Simil
Department of Important: If I any injury or once	All O	('0(1			De	Vol Fune	ral Hom	e	
	Jones	Dur	my				r., Gait			
	23a. Part1. Entar tha disaasa, or comp shock, or haart tailure. List only o	lications that caused the	a daeth. Do no	t enter the mo	da of dyling, s	uch as cardiac	or raspiratory arra	st,	Appr	oximate val Batween
g physician and as the burial-transit	disease or condition rasulting in death) a. Acute Arrythmia Minu Due to (or as a consequence of):									
physician and street transit to buriel-transit edical Examiner	Sequentially list conditions. Due to (or as a consequence of):									- 1
urial E	if eny, laading to immadiata cause. Enter Underlying Cause (Disease or Injury								1	
he b	Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as e consequence of):								1	
0										
ns S		d							1	
d for	Part II. Other significant conditions co	ntributing to death but r	not rasulting in t	ha underlying	cause given i	n Part I.	23b. Dld to	bacco use con	tribute to the	cause of de
gned by the attending be detached for use a by Physician/M				79		741			3 Probably	
bede de	Congestive Heart	Failure						3		
been signed by the attendir should be detached for use leted by Physician/N							24a. Was a		24b. Were au	topsy findin
artificate has been sinctor, page 2 should	Diabetes Mellitu	18					perform	1001	complate of death	prior to ion of cause
ge 2								-00		
r. page							1 □ Ya		1 ∐ Yas	2 No
certificate rector, pay	25. Was casa refarred to medical axaminer?	Hoenite!				6. Placa of Dea	th (Check only on	a)		
this carried direction of the carried directio	TU Tes ZINO	Hospitat: 1 Inpatient				4 ☐ Nursing H	ome 5 Resida			
ther unen	27. Mannar of Death 1 ☑ Natural 5 ☐ Pending	28a. Data of Injury (Month, Day Y	(ear) 28b. Tir	ury	28c. Injury at Work?		28d. Describe ho	w injury occurr	ed	
he f	2 ☐ Accident invastigation			М	1 🗆 Yas	2 No				
is after death. al Director: After t led in by the funeral Certification:	3 Suicide 6 Could not be determined	28a. Place of Injury building, etc. (n, street, facto	ry, office	11, 2	28f. Location (St.	reet and Number, Stata)	er or Rural Rou	ta Number,
od in		55.00. g; 510. (.,,/							
within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be		sician: To the best of r ner: On the basis of as and manner state	camination and/							cause(s)
ompl	29b. Signatura and titla of certifier			29	c. License nu	umber	2:	d. Date signed	(Month, Day,	Year)
× ⊢ 0	1 A . H	97	MA		001	a Da	7	5/		100
	12mm A	farma,	Mell.		NSI	180		eginar	1 20,	177
	30. Nama and addrass of person who of	ompleted cause of dela			1 11	1 100	- CA	(
	9901 Mydical (enter Dril		ckvill	e MO	208	30			
State Registrar	31. Data filed (Month, Day, Year) FFR 2 2 100	32. Registrer's	Signature	4						

DHMH 16 Rev 6/95



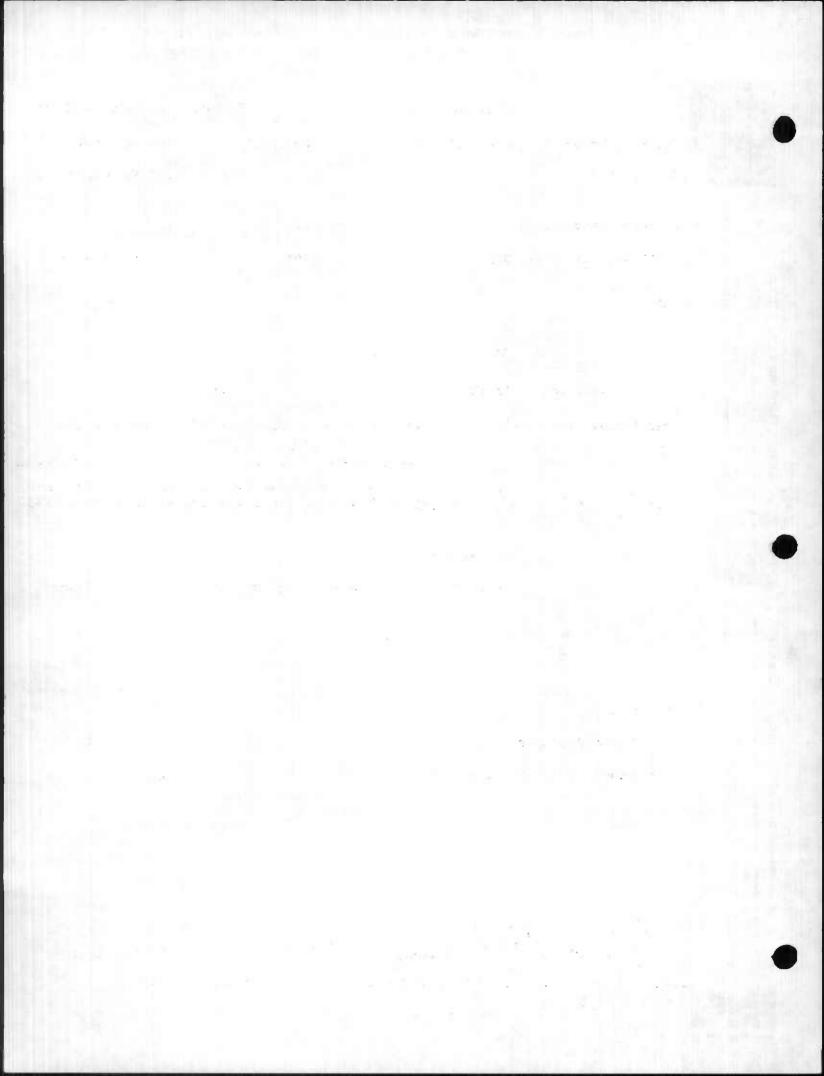
edical Examinet must be noticed at the control of t	4e. Fecility Neme SUBURBA 5. Social Security 579-01- Usual Residence 10a. State N/A 10e. Street end No	of Decedent 10b. County N/A						4b. City, Town	FEBRU. or Location of De			3. Time of Death 5:56 A.M.	
eral	SUBURBAI 5. Social Security 579-01- Usual Residence 10a. State N/A 10e. Street end No. 3446 CO	N HOSPITA Number 6. 1131 of Decedent 10b. County N/A	L Sex	7. Age (In yrs.				4b. City, Town	or Location of De	eth 4c. Coun	ty of Deeth		
tor	579-01- Usual Residence 10a. State N/A 10e. Street end N 3446 CO	of Decedent 10b. County N/A				40 4 1 4		BETHES	own, or Location of Deeth 4c. County of Deeth MONTGOMERY				
Funeral Director	10a. State N/A 10e. Street end Ni 3446 CO	10b. County N/A			Months Day				Ain. (Month,	of Birth h, Dey, Yeer) 28, 1916 9. Birthplace (Stete or Fo Country) VIRGINIA			
Funeral Director	10e. Street end No. 3446 CO			10c. City, Town or Location							1	0d. Inside City Limits	
ret must be no Funeral Dire	3446 CO	umber	WASHIN			NGTON, D.C.						¹X Yes 2□No	
Tune	11. Marital Stetus	3446 CONNECTICUT AVENUE, NW			10f. Zip Code 20008					10g. Citizen of Whet Country? U.S.A.			
1 by I	1 Never Married 2 Married 3 Widowed 4 Divorced		12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:			 13. Was Decedent of Hispenic Origin? (Spif Yes, specify Cuben, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify: 			? (Specify Yes or uerto Rican, etc.)			Race - American Indien, Bleck, White, etc. WHITE	
Completed	15. Decedent's Ed (Specify only highest gre-		ducation ade completed) College (1-4or 5+)		16e. Decedent's Usual Occupetion (Give kind of work done during most of work life. DO NOT use retired) TELEPHONE OPERATOR			working	16b. Kind of	6b. Kind of Business/Industry			
dwo	Elementary/Secondary (0-12)								C&P TE	LEPHO	NE COMPANY		
Be C	17. Father's Neme (First, Middle, Last)									it, Middle, Meiden Sumeme)			
		E BARKER						VIOLA	BALL				
To	19a. Informant's Name/Reletionship (Type, Print) DORIS McAFEE DAUGHTER				19b. Mailing Address (Street end Number or Rurel Route 1518 ANITA ST., BOSSIER CT								
ury or other	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)			74-4-	bb. Place of Disposition (Neme of cemetery, cremetory or other place) NATIONAL MEMORIAL PARK 3/					9 FALLS CHURCH, VA			
any injury or	21. Signature of Funeral Service Licenses 22. Name end Address of Facility JOSEPH GAWLER'S SONS, INC. 5130 WISCONSIN AVENU NW, WASHINGTON, D.C. 20016												
	23a. Pant Enter the designs or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate										Interval Between		
ian cal	Immediate Cause (Final disease or condition		Onset and Death SEPTICEMIA										
miner	resulting In deeth)	_	CONGESTIVE HEART FAILURE										
o the bunar-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events		ATRIAL FIBRILLATION										
is	that initieted even resulting in deeth)	s Lest	ANE	1IA Due to (d	or es e conseq	uence of):							
Physician/N	Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.						ven in Part I	23b. D	23b. Dld tobacco use contribute to the cause of death?				
										☐ Yes 2 No		bably 4 Unknow	
leted by					4					performed? evailable		ere eutopsy findings ailable prior to mpletion of cause deeth?	
Comp									10	Yes 2 No	10	Yes 2□ No	
Be ag	25. Was cese refe exeminer?	_	Mospital				0.1		Death (Check onl	y one)			
et	1 ☐ Yes 2 ☐ 27. Menner of Dee			npatient 2 finiury	ER/Outpatien			4 Nursir	g Home 5 Re	sidence 6 🗆 O		y)	
To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	1 Natural 2 Accident	5 Pending investigation		a. Date of Injury (Month, Dey Yeer) 28b. Time of Work? Injury M 1 Yes 2 No					200. Describ	200 Dood lot Hall Hally cood lot			
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location City or 7	28f. Location (Street end Number or Rural Route Number, City or Town, State)				
										tated. the ceuse(s)			
	29b. Signature and title of certifier 29c. License numb					e number	ber 29d. Date signed (M			Dey, Yeer)			
	· a	~. c	D0006198					FEBRUARY 23, 1999					
	30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) WILLIAM C. LIU, M.D., 2902 PORTER STREET, NW, WASHINGTON							NOMON S	00000				
State	31. Dete filed (Mar	U. LIU,	M.D., 29	902 POR gistrer's Signa		KEET,	NW	, WASHI	NGTON DC	20008			

GRACE Studen Feb-20,1999 556 AM

Land Street, 19 and 19

		State	or maryia		artment of rtificate of	Health and I Death	Mental Hy	Reg. No.	9 0	7322		
Physiciar /Medica								2. Date of Death Month Day Year February 20, 1999 4:30 pm				
Funeral Director			the Annapolitan 7. Age (In yrs. last birthday) If Under 1			Annapol r If Under 24 Hrs Hours Min.	8. Date of Bi	Anne	Year) Country)			
pue M.	Usual Residence of Decedent 10a. State 10b. Cou		10c. 0	City, Town or Lo	cation				10	d. Inside City Limits		
vith the Maryle or 28a-f sho	Maryland Anne Arundel Annapolis 10. Streel and Number 10. Zip Code											
U20 urs after death v ur, or fterns 23s kenviner must	6 17 Admiral 11. Marital Status 1 Never Married 2 N 3 Widowad 4 Divore	12. Was D Armed farried 1 1 Ye	Decedant Ever in I Forces? es 2 🕅 No		Was Decedent of If Yas, specify Cu 1 ☐ Yes 2 🕅 No	21401 Hispanic Origin? (S ban, Mexican, Puarl Specify:	Specify Yas or N to Rican, etc.)		cates n Indian, tc.			
be filed within 72 hours at tall Hygiene. It defined then "naturel", or event, the Modreal Example Bo Commission by It	15. Dece (Specify only hig Elamantary/Secondary (0-1:		ed) ea (1-4or 5+)	(Give	Auditor Auditor			16b. Kind of Business/Indus U.S. Governme				
The Med A	Perc	J							ne (First, Middla, Malden Surname) Rose Toy			
all more, Marimit Pages 1 and 2 sho partment of Health and portant; if them 27 is m y injury or other traum	19a. Informant's Neme/Reletionship (Type, Print) Lois Hungerford / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 617 Admiral Drive #202 Annapolis, Maryla 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State								cyland City or Tow	21401		
Physician	22. Nema and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. M00335 300 West Montgomery Avenue Rockville, Maryland 20850 23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death											
 /Medical Examiner 	Immediate Cause (Final disease or condition resulting in death) Respiratory Arrest Due to (or as a consequence of):											
death certificate be executed e attending physician and dor use as the burial-transit	Sequentially list conditions, if any, laading to immadiate cause. Entar Underlying Cause (Diseass or Injury that initieted events resulting in death) Last Chronic Obstructive Pulmonary Disease Years Due to (or as a consequenca of): Due to (or as a consequence of): d.											
at the death certification by the attending etached for use as	Part II. Other significant cond	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								the cause of death?		
S the set of set		10	1 ☐ Yes 2 No 3 ☐ Probably 4									
The law require sate has been single 2 should I	Renal Insuff		24a. Was an autopsy performed? 24b. Were auto-syallable completio of death?									
VICAL MEG sician: The law certificate has b lirector, pege 2 s										IYes 2□ No		
Of VITA Physician: this certific ral director,												
Affect fune		estigation (A	28a. Data of Injury (Month, Day Year) 28b. Tima of Work? Injury 1 Yes 2 No					28d. Describe how Injury occurred				
To the Hospital or Attend within 24 hours after deal To the Funeral Director: completely filled in by the	3 Suicide 6 Cou	armined 286. Pi	uilding, etc. (Spe	cify)	reet, factory, office	n (Street and Number or Rural Route Number, Town, State)						
the Hospital or in 24 hours after the Funeral Dir nplately filled in	29a. Carliflar (Check only one) 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and due to the cause(s) and mannar as a construction of the cause of								and due to	tha cause(s)		
To the compl	29c. Licensa a D22						29d. Date signed (Month, Day, Year) February 22, 1999					
	30. Name and address of pers Paul S. Rhodes					ofton, Ma	arvland	21114				
State Registrar	31 Date filed (Month Day Ve	ar) 32	2. Begistrar's Sig	nature	Spork		ar y rand	21117				

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give stre 4c. County of Death Examiner SPRING MONTGOMER 7. Age (In yrs. last birthday) If Under 1 Year Months Days 9. Birthplaca (Ste Country) MASSACH 5. Social Security Number **Funeral** 1□M 20 F Days Hours 38 5984 AA Yrs. Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumetic avent, the Medical Examiner must be notified at SILVER 1 Yes 2 No Director MONTGOMERI 28e-f 10e. Street and Number 10g. Citizen of What Country? 5 20910 Norma 23a ROAD permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itema 23a any hilury or other traumatic avent, the Medical Experient market. Funeral 12. Was Decedent Ev Armed Forces? 1 Yes 2 No N Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ANTHROPOL DGIS 17. Father's Name (First, Middle, Last) FLOREN(F 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SILVER SPRING MD ZO910 DT, HUSBAND 526 DAVE GROEN FEL 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 4 ☐ Donation—5 ☐ Other (Specify) ESAPEAKE CEMATON INC Z. 23.99 BELTS VILLE MD
22. Name and Address of Fability PANID GROENFELDT, HUSBAND 5 ☐ Other (Specify) 21. Signature of Fungral Service Lic 526 ASHFORD RD. SILVERSPRING MD Z0910 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ERVICAL CANCER Immediate Cause (Final disease or condition resulting in death) no /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ page 2 should b 24b. Were autopsy tindings available prior to completion of cause of death? edical Certification: To Be Completed 24a. Was an autopsy 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vitai 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 3 DOA 5 Residence 8 □Other (Specify) 2 ER/Outpatient this 27. Manner of Death 1 E Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t Injury at Work? or Attanding 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atta within 24 hours after dea To the Funeral Directo completely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

Registrar **DHMH 16 Rev 6/95**

State

LomB

32. Registrar's Signature

CANCER CENTER, WASH, OC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAIYER RIZVI, UMB 40

31. Date filed (Month, Day, Year)

FEB 23

the Table - The control of nath and guarantee Friend eller in action as process The contract of the Street e modelle a seed of potable participation of TONE OF THE PARTY The same of the sa

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Deeth 1. Decedant's Name (First, Middle, Last) 3. Time of Deeth Feb. 17,1999 5:40 PM Stansbury Kane 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Manor Care Westwood Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 20,1907 Birthplace (State or Foreign Country)
 Ohio 6 Sav 7. Age (In yrs. last birthday) 1□M 2ŒF Months Days Hours Min Yrs. 91 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 5101 Ridgefield Road 20816 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: 14. Raca - American Indien. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: 3 N Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Mary Stanton James Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 4817 Butterworth Pl., N.W., Washington, D.C. 20016 Ann C. Stansbury/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 Buriat 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb.20,99 Calvary Cemetery Youngstown, Ohio 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W., Washington, DC 20007 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or haart failure. List only one cause on each line. days Influenza Due to (or as a consequence of): vears Alzheimer's Disease Due to (or as a consequence of): Due to (or es e consequenca of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Breast Cancer 24b. Wera autopsy findings available prior to 24a. Was an eutopsy

Physician /Medical Examiner

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Box 68760.

Records, P.O.

Division of Vital

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Certification:

permit. Peges 1 and 2 sh Department of Health and Important: If I fem 27 is my any Injury or other treum, once.

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumetic event, the Medical Examiner inset be notified at

2 should be filed within 72 hours after and Mantal Hygiene.

Baltimore, Maryland 21215-0020

the Maryland

death

5. Social Security Number

295-54-3589

10e. Street and Number

10a. State

Director

Funeral

p

Completed

Be

Usual Residence of Decedent

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that Initiated events resulting in death) Last

25. Was cese referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

4 Homicide

3 ☐ Suicide

29a. Certifier (Check only one)

Immediate Ceuse (Final disease or condition resulting In death)

20a. Method of Disposition

completion of cause of death?

1 Yas 2X No

1 ☐ Yas 2 ☐ No

26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28a. Data of Injury (Month, Day Year)

29c. License number D39456

28c. Injury at Work?

29d. Date signed (Month, Day, Year) February 18,1999

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

McConnell, M.D., 5530 Wisconsin Ave., Chevy Chase, Md. 20815

State Registrar 31. Date filed (Month, Day, Year) FEB 2 3 1999

5 Pending

invastigation

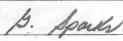
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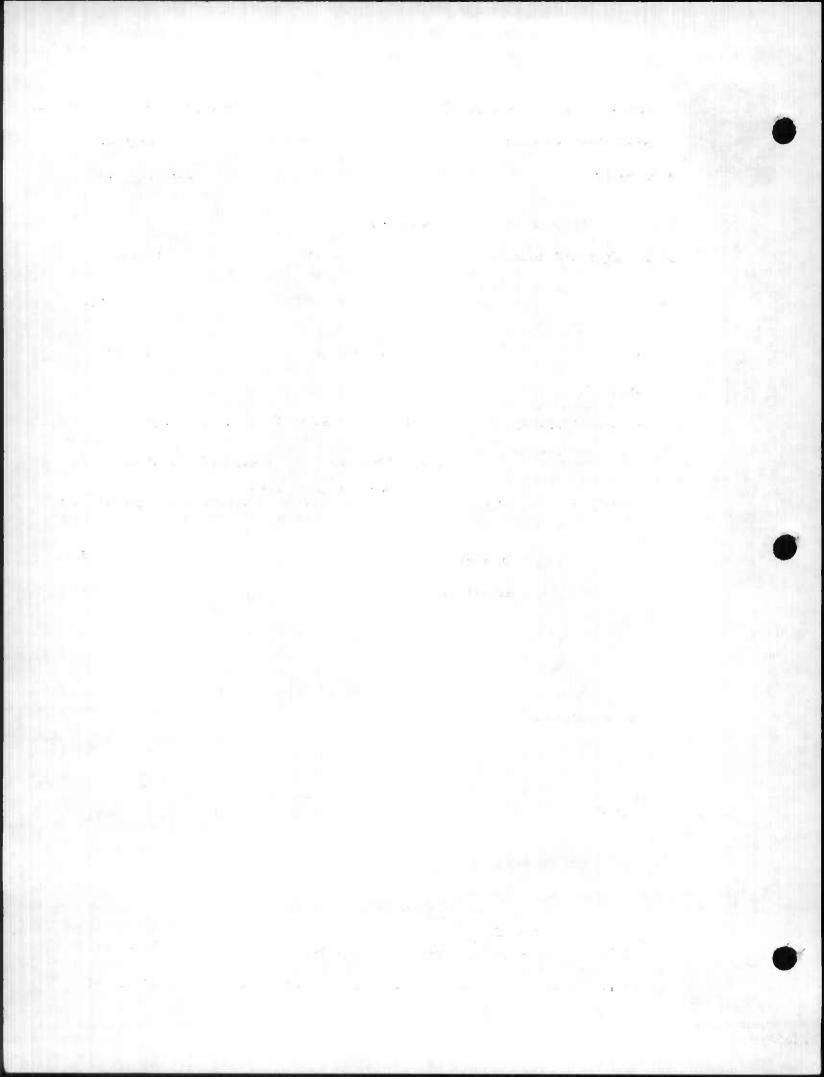
32. Ragistrar's Signature

1 inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

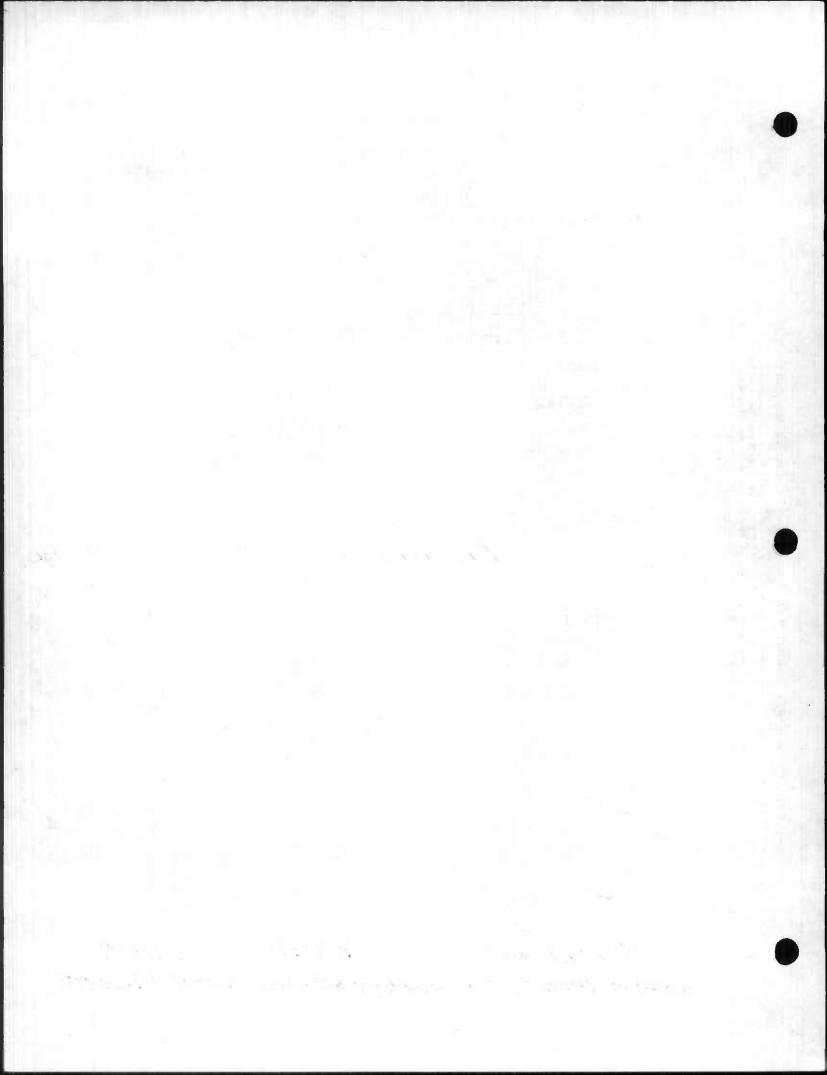




State of Maryland / Department of Health and Mental Hygiene 9 9 0 7 3 2 5

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	1. Decedent's Name (First, Middla, Las	st)					2. Data of Do Month	eath	Vana	3. Tima of D	leath
Physician /Medical	Elizabeth Stephe	ens	ol _e				Februa	ary 20,	1999	3:08	AM
Examiner	4a Facility Nama (If not institution, give	street and number)				4b. City, Town, o	or Location of Dea	th 4c. Cou	nty of Death		
	Randolph Hill No	ursing Center				Wheaton		Mon	tgomer	У	
Funeral Director	5. Social Security Number 6. Se 129–28–7825	ex	rs. last birthda 7 Yrs.	y) If Und Month	ar 1 Yaer S Deys		n. (Month, D	rth ay, Year) 11, 191	Coun	place (Stata or F http:) :h Caro	
2 .	Usual Residence of Decedent										
Sa-f show attiled at	10a. Stata 10b. County Maryland Prince		City, Town or I Lanham	Location					1	0d. Inside City 1 X Yas 2	
Dire Dire	10e. Street and Number 6907 Woodstream	Terrace			Zip Code				of What Cour		
L', or Items Examiner in by Funer	11. Merital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Dates:	U,S. 13		cedent of becify Cut 2X No		(Specify Yas or N erto Rican, etc.)		Race - Americ Black, White, Boilty: Blac	etc.	
natural disal	15. Decedent's Ed (Specify only highest grad		16a. Dec	edent's Us	suel Occu	pation	ndina	16b. Kind o	f Business/Inc	dustry	
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E E	19a. Informant's Neme/Reletionship (7	ype, Print)	19b. Ma	iling Addre	ss (Stree	t end Number or	Rural Route Numb	ber, City or To	wn, State, Zip	Code)	
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ysician Medical	21. Signature of Funeral Service Licens 23e. Part1. Enter the disease, or compshock, or heart failure. List only of	megnin	e	McGu:	ire E Geor	gia Ave	Service, N.W., V	Vashing	gton, D	Approximata Interval Batwe Onset and De	
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	axaminer?	Hospitel: 1 ☐ Inpatient 2	☐ ER/Outpati	ent 3	DOA O	her: 4 Dentring	Home 5□Res	idence 8 🗆	Other (Specif	(y)	
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	of M		ıryat ork?]Yas 2 ∐No	28d. Describe	how injury oc	curred				
- 4.5 E	3 Suicide 6 Could not be detarmined	28a. Place of Injury - A building, etc. (Spe		street, fact	ory, office			(Street and No own, State)	imber or Rure	al Routa Numbe	ΘΓ,
Funer etely fill dical	29a. Certifier (Check only one)	ime, data end pla opinion, daath oc	ce, and dua to the curred at the time	causa(s) end , date and pla	manner as s ce, and dua to	tated. o tha cause(s)					
within comple	29b. Signetura end titla of certifier	1		2	9c. Licen	se number		29d. Data sig	gned (Month,	Day, Year)	
1/	* HAR Roses	chaeen				9834		2/	20/8	9	111
	30. Name and addrass of person who c	AOM 3720	FARK	Print)	T AU	5. KE	USINGT	ONIN	W. 2	0898	
State	31. Data filed (Month, Day, Year)	32. Registrar's Sig	onatura /		1						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** 3:30 AM Glenn Vincent Swengros February 21, 1999 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner | Chevy Ones | S. Data of Birth (Month, Day, Year) | Sept. 23,1931 Manor Care - Chevy Chase Montgomery 9. Birthpiaca (Stata or Foraign Country) Missouri 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1[XM 2□ F Yrs 500-26-6654 Director 67 Usual Residence of Dacedant with the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☒ No Director 20895 Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 9807 Hill Street 20895 USA deeth v Funeral 14. Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Haelth and Mental Hygiena. Important: If item 27 is marked other than "natural", or iter any injury or other traumetic event, the Modical Examine once. 1 X Yas 2 □ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 X Married White Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: P 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Physical Education/Fitness Elemantary/Secondary (0-12) College (1-4or 5+) 5+ Director of Programming 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be Rudolph Swengros Josephine Morr 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 9807 Hill St, Kensington, MD 20895 Mary Alice Swengros/Wife 20b. Placa of Disposition (Nama of cemetary, cremetory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 2/28/99 Alexandria, VA 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Cemetary 22. Nama and Addrass of Facility Frances J. Inc. 500 University Blvd. Collins Funeral Home West 21. Signatura of Funaral Sarvice Licansas Silver Spring, MD 20901 | Silver Spring, FID 20901 23a. Parti Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Oligodindiogeroma of Bram and asperation Pneumonia. Examiner Due to (or as a consequence of): Physician/Medicai Examiner ettanding physician and for use as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiate ceuse. Enter Underlying Ceusa (Disaasa or Injury thet initieted avents resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to should I 24a. Wes an autopsy performed? Completed complation of causa of deeth? irector, page 2 s 1 Yes 2 No 1 ☐ Yas 2 ☐ No Physician: 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 After this 28d. Dascribe how injury occurred 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: or Attending 1 Neturel 5 Pending invastigation death. 1 Tyes 2 No 2 Accident Director: / 28f. Location (Straat and Number or Rural Route Number, City or Town, Steta) 6 ☐ Could not be 28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) To the Hospital or within 24 hours after de To the Funeral Direct 3 ☐ Suicida 4 Homicida 12 Cartifying Physician: To the best of my knowledge, daath occurred et tha time, date end plece, and dua to the cause(s) end menner es stated edicai 29e. Cartifier 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signatura and titia of cartifian 29c, Licansa number 29d. Data signed (Month, Day, Year) 2-21-99 005373 Denned a. Heckerson, M.D. 30. Nama and addrass of person who complated causa of deeth (Item 23e) (Type, Print)

8830 Cameron St. #405, Silver Spring, MD 20910-4114

DHMH 16 Rev 6/95

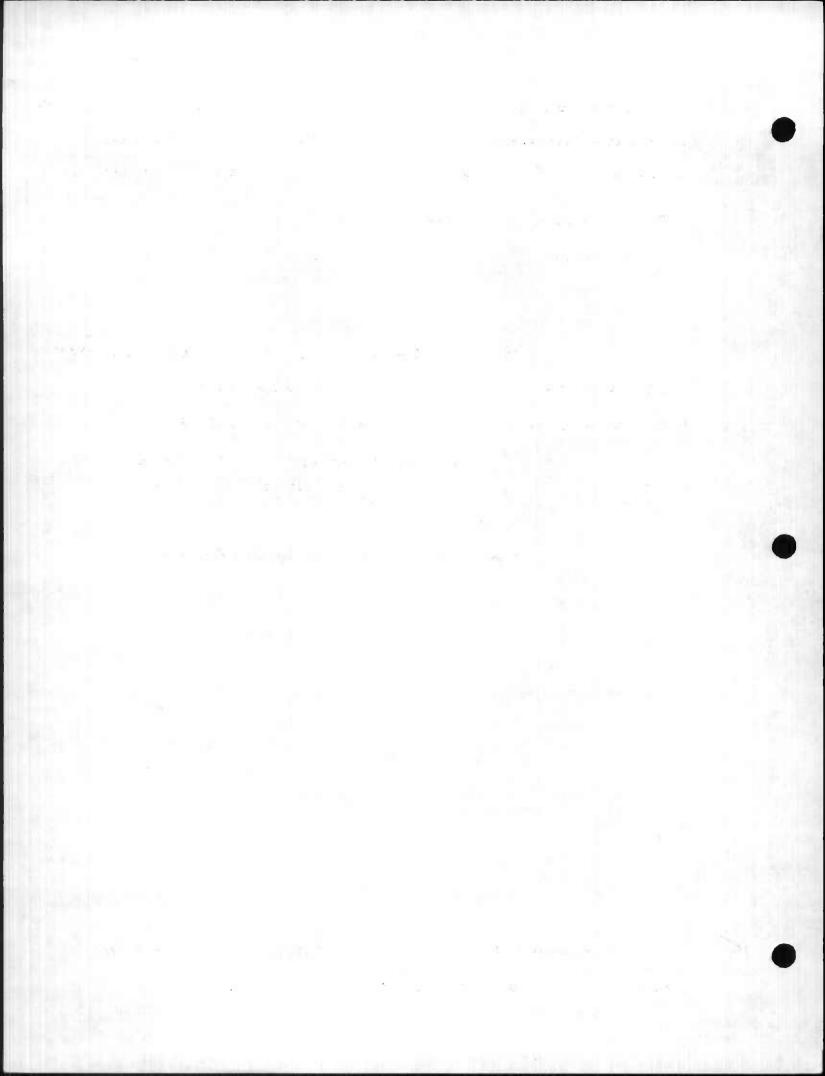
State

Registrar

Bernard A. Heckman, MD EB 23

32. Ragistrar's Signatura

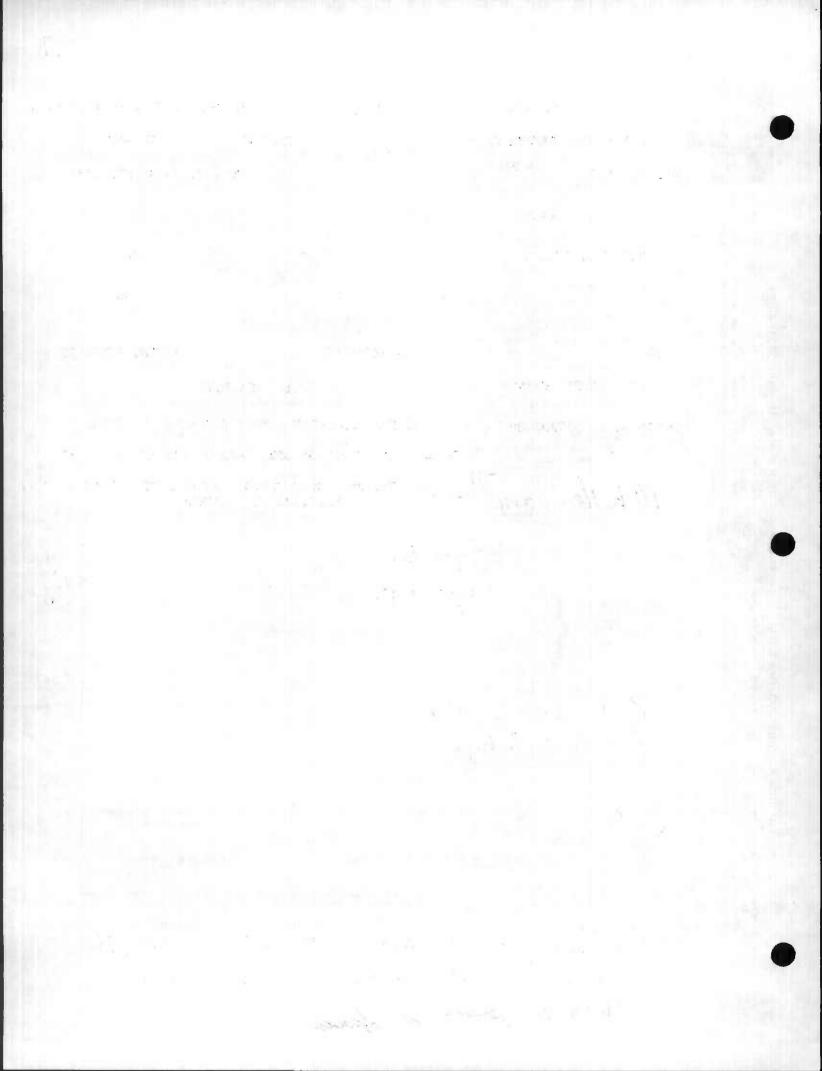
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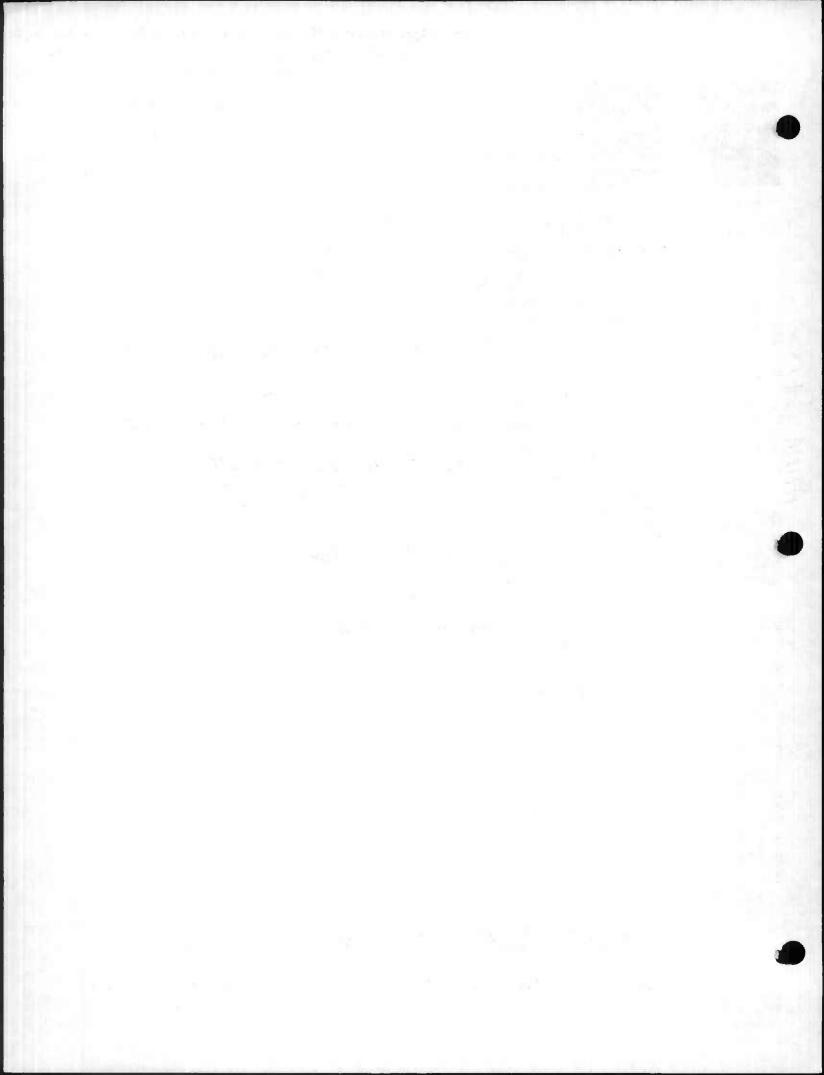
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Physician	1. Decedent's Name (First, Middle, L	ast)				2. Dete of Dee Month	Day	3. Time of Death
/Medical	MAY C	CANNON	SI	JLLIVAN	4b. City, Town, or	FEBRUA		1999 2:35am
Examiner	WILLIAM HILL H	3, 300			EAST			ВОТ
Funeral		Sex 7. Age ((In yrs. last birthday)	If Under 1 Year Months Devs	If Under 24 Hrs Hours Min.	8. Date of Birt	h -	Birthplace (State or Foreign Country)
Director	483-03-6813	1□ M 2XQXF 90	Yrs.	Months	TIOUIS WIII.	NOV. 7		DELAWARE
and and	Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or Lo	cation				10d. Inside City Limits
Many Hahr	MD T	CALBOT	EASTON					XXYes 2□No
with the Marylan a or 28a-f ahow the notified at	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Vhet Country?
23a c	503 DUTCHMAN'S L	ANE			1601		US	
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l X I X I D-UUs led within 72 hours lygiene. Ner then "naturel", nt, the Medical Ex Completed by	15. Decedent's t	Education	(Give	dent's Usuel Occup	during most of wa	rkina	16b. Kind of Bu	siness/Industry
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be filed to that Hygie d other teams.	10 17. Father's Name (First, Middle, Las	st)	SEA	AMSTRESS	18. Mother's Na	me (First, Middle,		INDUSTRY
Viano vuid be fii Mental H Mental H inked oth rice ven	CHARLES HENRY	CANNON			ALMA	KALTON		
Maryland 12 should be file h end Mental Hy 7 la marked oth traumatic avant To Be (19e. Informent's Neme/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or R	urel Route Numbe	er, City or Town,	Stete, Zip Code)
2 = 2 -	DAVID W. SULLIVA	N/SON		UN RISE I	DRIVE, MO			
Pages 1 nent of H mt. If ite	20e. Method of Disposition 1 ☐ Buriei 2 【X Cremation 3		20b. Placa of Dispo cametery, crer CHESAPEAK	natory or other ple		Date 2 - 2 5 - 0 0		City or Town, State
Deartimore, permit. Pages 1 er Department of Hea important: If item: any injury or other once.	4 Donation 5 Other (Spec			. Name end Addre		2-23-99	PIEAEMO	VILLE, FID
Deperment important	23a. Part1. Inter the disease, or conshock, or heart failure. List only	name	FSP F	ELLOWS, 1	HELFENBEI	C., EASTO	ON, MD 2	RAL HOME, P.A. 1601 Approximate Intervel Between
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	. Deh	y dration					Onset end Death
je in			lie to (or es e consec	quence of):	n Socto	122		516
be executed sician end bunal-transit	Sequentially list conditions,	b. Dy	a to (or as a consec	quence of):		,,,		3
be exe cian e burial.	Cause (Disease or injury	С						
ifficate g physes the	that initiated events resulting in death) Lest	Du d	ue to (or as a conseq	uenca of):				
. 0 00	Part II. Other significent conditione	contributing to death but	not resulting In the u	nderlying cause gi	ven in Pert I.	23b. Dld 1	lobacco use col	ntribute to the cause of deeth?
	Practure Fracture	on n	Niscare			10	Yes 2 No	3 Probably 4 Unknown
The law requires that the law requires that the page 2 should be detached.	Fractur	e & hij	>			24e. Wes perio	an eutopsy rmed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
= F # B 0						101	res 20 No	1 ☐ Yes 2 ☐ No
ysician: The s certificate director, pag	25. Wes case referred to medical examiner?	Hospital:	2 ER/Outpatier	Ot		eth (Check only o		4. 4.
F Sign	1 Yes 2 ANo 27. Manner of Death 1 Naturel 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Dey)	ry at rk? Yes 2 No	Home 5 Resid	denca 6 □Oth now injury occur			
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not 4 Homicide determine	be d 28e. Placa of Injury building, etc.	y - At home, farm, str (Specify)	reet, factory, offica		28f. Location (3 City or Tox		er or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29e. Certifier 1 ☑ Certifying P (Check only one) 2 ☐ Medical Exa	Phyaicien: To the best of raminer: On the basis of examiner and menner state	xamination end/or in	n occurred at the ti vestigation, in my	me, date and plec opinion, death occ	a, and due to the urred et the time,	ceuse(s) end me date and placa,	enner as steted. end due to the ceuse(s)
within of the omple	29b. Signeture end title of certifier	And member state		29c. Licen	se number		29d. Date signe	d (Month, Dey, Year)
F ≯ F Ö	> William	1th word	10 Mg))	88715		2/29	798
	30. Name and address of person who			Print)			MD 2160	01
State Registrar	31. Dete filed (Month, Day, Year) FEB 2 6 19	32. Registrar	s Signature	,				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physic		Decedant's Nama (First, Middla, Lat ANNA MARIE SAX					2. Data of De Mooth FEBRUARY		3. Tima o 9 2:40	
/Medi Examii		4a. Facility Nama (If not institution, give	a streat and number)				r Location of Death	4c. County	of Death	111
uneral rector		CIVISTA MEDICA 5. Sociel Security Number 6. S 154-09-1255		yrs. last birthday) Yrs.	If Undar 1 Months D	LA PLATA Yaar If Undar 24 Hr Days Hours Mir	s. 8. Data of Bird Month, Da June 26	CHARLE	9. Birthpleca (Stata o Cquetry) Indiana	or Fore
ž		Usual Rasidance of Decedant 10a. Stata 10b. County	100	. City, Town or Lo	cation				10d. Insida C	
r 28a-f show rnotified at	tor	MD Charles		La Plat					†€ Yes	-
23a or 28	Funeral Director	10e. Street and Number 10200 La Plata	a Road		10f. Zip Co			10g. Citizan of V USA		
al', or itams Examiner m	by	11. Marital Status 1 Navar Marriad 2 Midowed 4 Divorced	12. Was Decedant Evar Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:		Vas Decedan f Yas, specify I□ Yas 2	t of Hispanic Origin? (Cuban, Maxicen, Pua No <i>Specify:</i>	Specify Yas or No into Rican, atc.)		e - Amaricen Indian, ck, Whita, atc. .: White	
r than "natural", the Medical Ex	Completed	15. Decedant's Ed (Specify only highast gra Elementary/Secondary (0-12)	ucation da com <i>plated)</i> Collega (1-4or 5+)	(Giva		occupation tona during most of w atired) r/Office			usinass/Industry	
vent,	Bec	17. Fethar's Nama (First, Middla, Last)			-		ama (First, Middla,		ia)	
7 is marked traumatic s	70	Louis Riffle	Sun a Christian	AND BANKS			sa Whel			
2 5		Marilyn Little				ewood Dr				
r other tr		20a. Method of Disposition 1 Burial 2 Cramation 3	20	b. Place of Dispos cematary, crem	sition (Nama	of	Data		City or Town, Stata	
ant: If It		4 Donation 5 Othar (Specify		Metropo	litan	Cremato	ry2/26/	99 Ale	xandria,	VA
Important: If I any Injury or once.		21. Signatury of Junaral Sarvice Licen 23a. Part1. Entar tha disaasa, or compshock, or heart failure. List only in	saa	22 A	Nama and A	ddrass of Facility	FINEDA	T UOME	D A	
ettending physician and for use as the buriel-trensit	n/Medical Examiner	resulting In death) Sequentially list conditions, if any, leeding to Immadiate cause. Enter Underlying Causa (Disaasa or Injury thet initieted avants resulting in death) Last	b. Pepult Duat c. Opua Duat	o (or as a consequence of the or as a consequence of or a consequence or a consequence of or a consequence or a	yando of): uance of): uance of):	21		ı		
ed by the ette detached for	Physician/N	Part II. Other significant conditions co	ntributing to death but not	rasulting in tha un	ndarlying ceus	a givan in Part I.	23b. Dld 1	obacco uae coi	ntribute to the cause	of de
gned by t be detach	by Phy						1	Yes 2□No	3 Probably 4) Unk
hes been signed t ge 2 should be det	Completed						24a. Was perfo	an autopsy med?	24b. Wara autopsy i available prior t completion of c of death?	to
certificate he rector, page	Be Co	25. Wes cesa rafarrad to medical				26. Placa of Da	aath (Chack only o	41	1 ☐ Yas 2 ☐	J No
this certific al director,	ToE	axaminar? 1 ☐ Yas 2X No	Hospital: 1 XInpatiant	2 ER/Outpatient	t 3□ DOA	Other:	Homa 5 ☐ Rasio		ar (Specify)	
After	Certification:	27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year	28b. Tima of Injury	28c.	Injury at Work? 1 ☐ Yas 2 ☐ No	28d. Dascribe h	now injury occurr	red	
	Certifi	3 Suicida 6 Could not be datamined	building, etc. (Sp.				City or Tox	vn, State)	er or Rural Routa Num	nber,
lled in by t		29a. Certifiar 1 th Certifying Phy (Check only 2 Medical Exam	alclan: To the best of my inar: On the bests of axam and mannar stated.	knowledge, death Ilnation and/or Inv	occurred at to estigetion, in	ha time, data and plac my opinion, daath occ	e, and dua to tha curred at tha tima,	ceuse(s) end me data and place, a	enner es steted. and dua to tha causa(s	s)
Funeral Direct etely filled in by t	dica	one)								
To the Funeral Director: completely filled in by the	Medicai			m3		cansa number		1 1	d (Month, Day, Year)	
To the Funeral Direct completely filled in by t	Medical	one)	Teult ,	m3	D-2	cansa number 1031		29d. Data signed 2/25/4		



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** SR. 2045 SMITH FEBRUARY WALTER LEON /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth Examiner PRINCE GEORGES DRIVE 29115 HEMPSTEAD FORT WASHINGTON If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. lest birthday) **Funeral** Days 10 M 2□ F 85 Yrs. 404-10-3530 10, 1913 Tennessee Director Aug. Usual Residence of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a Stata 10b. County "naturel", or items 23a or 28a-f show social Examiner must be notified at 1 ☐ Yas 2 No Ft. Washington Maryland | Prince George's Directo 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code with 20744 U.S.A. 2915 Hempstead Drive Funeral filed withIn 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🐧 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indien, Black, White, etc. 11. Maritai Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Yaar or Datas: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mining Coal Miner other 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) . Pegas 1 and 2 should be fill ment of Health and Mentel Hant: If item 27 is marked out jury or other traumatic even Be Mollie Ellen Rice David Lawrence Smith 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nellie C. Smith/Wife 2915 Hempstead Drive, Ft. Washington, Md 20744 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pega Department of Important: If any injury or poce. Oakland Cemetery Feb. 22,1999 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Name and Address of Fecility
The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland DAVID A. GOFF M01095 mew Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximeta Interval Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the disease, or heart failure. List only one cause on each limit **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical · ARTERIOSCUEROTIC CARDIOVASCULAR Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leading to immediate causa. Entar Undarlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last end I-tran Due to (or as e consequence of): physician e Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) attending p signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown þ 24b. Were autopsy findings evaileble prior to completion of ceusa of deeth? been si 24e. Was an autopsy performed? Completed this certificate has rel director, page 2 20 No 1 Yas 2 No 1 Yes Division of Vital al or Attending Physician: The safter death.

I Director: After this certificated in by the funeral director, pe Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpetient 3□ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Yaar) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 DeNaturel 5 Pending Investigation 1 Yas 2 No 2 Accident 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated. 29a Certifier Medical 29c. Licensa number 29d. Date signed (Month. Dav. Year) 29b. Signature

State Registrar 30. Neme end address of person who complet

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FEB 26

MARIO 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

JR

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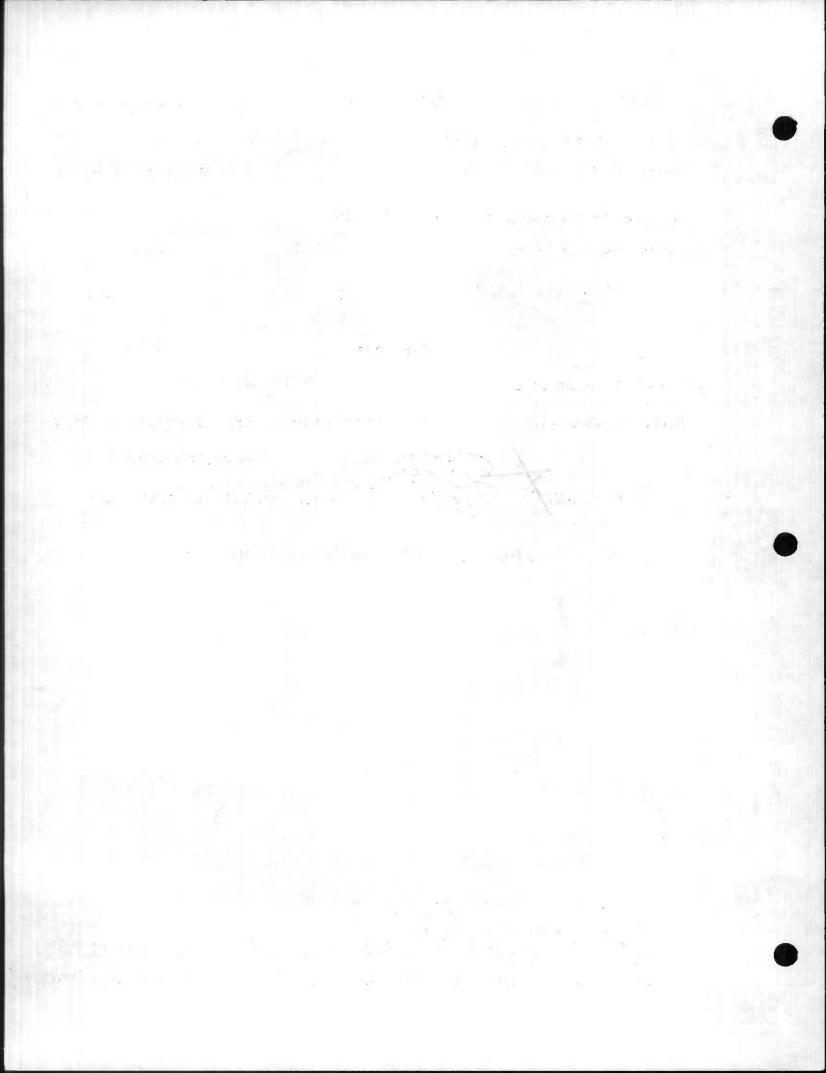
/23e) (Type, Print)

3001 HOSPITAL

DRIVE

CHEVERLY

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** moon Feb mari 1969 RAYMOND WARREN SIEGMYER 2) /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 82 FROST VILLAGE FROSTBURG ALLEGANY If Under 1 Year If Under 24 Hrs. Sex M 2□ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Yrs. 215 18 8954 76 Director MARYLAND Usual Residence of Decedent with the Mandend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo MARYLAND ALLEGANY FROSTBURG 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Peges 1 and 2 should be filed within 72 hours effer deeth v Department of Heelth and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Mental page. 82 FROST VILLAGE 21532 U.S. Funeral 14. Race - American Indien, 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married X Married 1 Yes 2√ No Specify: Specify. WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) LABORER BRICKYARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES W. SIEGMYER ANNIE DELPHIA LASHBAUGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY SIEGMYER / WIFE 82 FROST VILLAGE, FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) THE CUMBERLAND CREMATORY 2/27/99 CUMBERLAND, MD 21502 21. Signature of Funeral Service Licenses 22. Name end Address of Facility SOWERS FUNERAL HOME, P.A. Part. Enter the disease, or complications that ogused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. 60 W. MAIN ST., FROSTBURG, MD 21532 Approximete Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in deeth) MY CARDIAL IN FARCTINIX Examiner ARTERIOSCIENTE CARDICVASCULAR DIFFAID Examiner The law requires that the death certificate be executed physician and s the buriel-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): signed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1_Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to been sir 24a. Was en autopsy performed? Completed completion of cause of death? hes 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No this certificate al or Attending Physician: The safer death.

In Director: After this certificated in by the funeral director, pages. 25. Was case referred to medical examiner?

1 2 Yes 2 No Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Neturei 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospius within 24 hours effer To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one)

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State Registrar 31. Date filed (Month, Day, Year) FEB 2 6 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

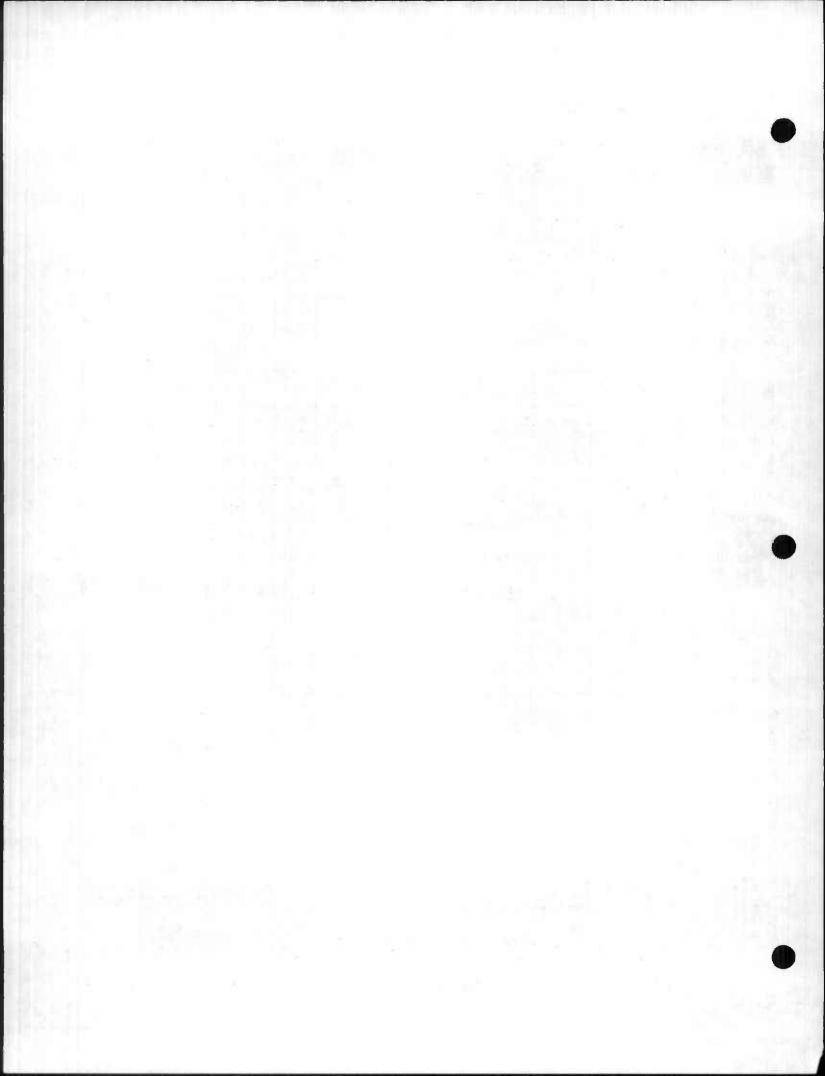
29b. Signeture end title of certifier

11600 Bed fite ROLL COIN CAND. MD. 1) (150 32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760



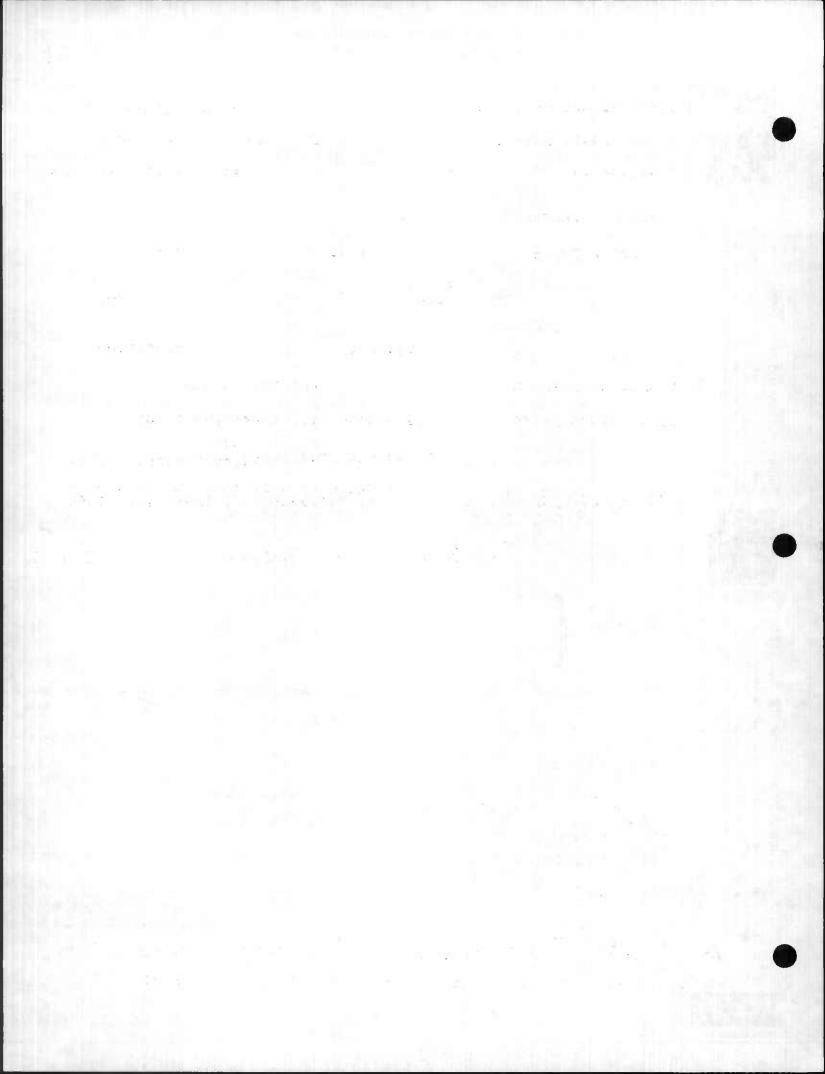
State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JAMES E. SWAUGER, SR. February 20,1999 2320 pm · /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY SACRED HEART HOSPITAL 6. Sax If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 10M 20F Months Days Hours Min Yrs JULY 23,1937 MARYLAND 219-34-6013 Director 61 Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylen Department of Health end Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examines must be notified at 1 Yes 2 No ALLEGANY LAVALE Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 26 HAROLD STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Baca - American Indian Black, White, etc. 1 Yes 2 No 1954-If Yes, Give Year or Dates: 1958 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2K No Specify Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 12 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LELAND R. SWAUGER BLANCHE LAYMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26 HAROLD ST., LAVALE, MD 21502 PEGGY SWAUGER/WIFE 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition FEB 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GRANTSVILLE CEMETERY 23, 1999 GRANTSVILLE, 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502 23a. Part 1. Enter the disease, or complications that cause of mean death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervet Between Onset end Deeth **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Examiner certificate be executed physician end the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as e consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 98 USB signed by the e 23b. Did tobecco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2€ No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evelleble prior to 24a. Was an autopsy Completed completion of cause of death? hes page 2 1□ Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: director. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 INo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 Natural 5 Pending after deeth. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours 29a, Certifie 12 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) To the P 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mu State

Registrar

GARY WAGONER, 31. Date filed (Month, Day, Year) FEB 2 5 1999

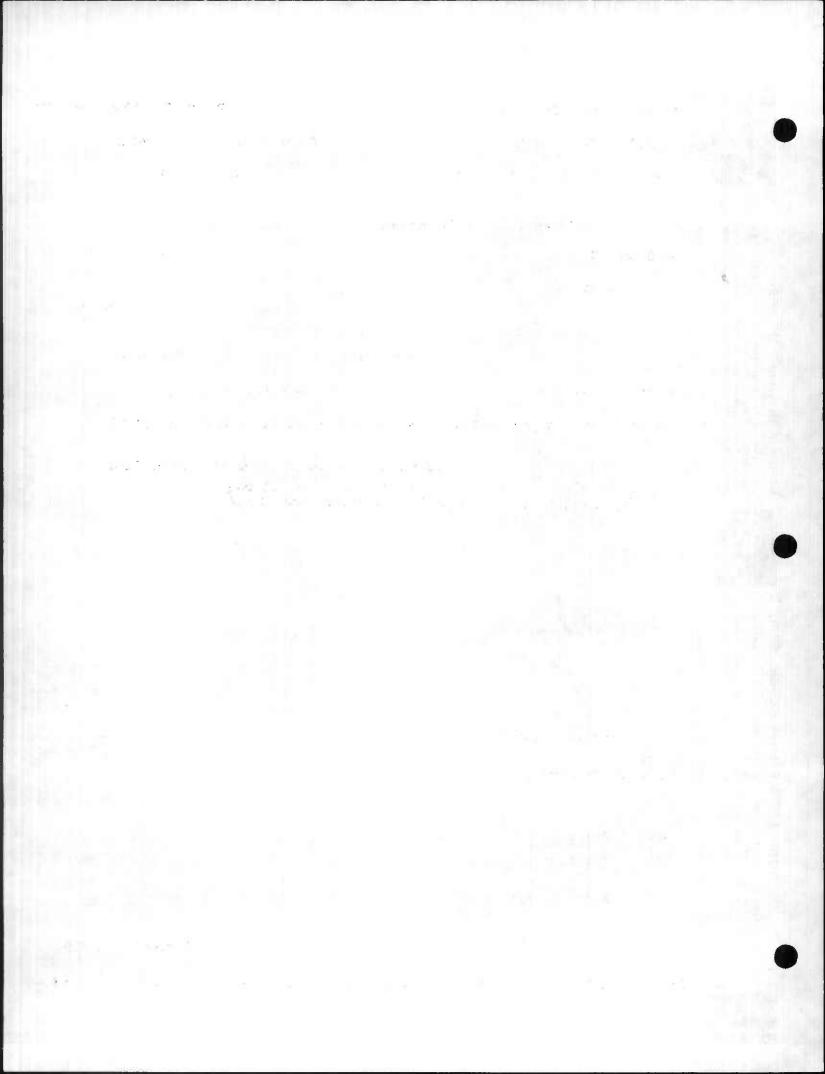
925 BISHOP WALSH RD., CUMBERLAND, 32/Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle	, Last)	(Certificate of	Death	2. Date of Death			Time of Deeth
Physician	BARBARA JEAN ST	TI.I.WAGON			Marie 10	FEBRUAR	Y 21, 19	999 20	027 PM
/Medical Examiner	4a Facility Neme (If not institution)		4b. City, Town, or Lo		4c. County of		
	SACRED HEART HO	SPITAL			CUMBERLA	ND	ALLEGA	NY	
Funeral Director	5. Social Security Number 235-70-3131	6. Sex 1 □ M 2√ F 7. A	ge (In yrs. last birth 52 Yr	Months Davs	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, Aug 10,		Country)	(State or Foreig
inyland show	Usual Residence of Decedent 10e. State 10b. County		10c. City, Town	or Location					nside City Limit
or 28a-fellor notified	MD Alle	gany	Cumber	land				X	Yes 2LIN
or 2	10e. Street and Number			10f. Zip Code		10	g. Citizen of Who	at Country?	
23a		t		21502	2		USA		
72 hours effer death with the Maryland naturel; or forms 23a or 28s-f ehow ord Examiner must be notified at each by Funeral Director		12. Was Decedent Armed Forces ad 1 Tyes 20 If Yes, Give Year or Dates:	No	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American In White, etc.	
n 72 hours naturel', noins Ex-			16a. D	ecedent's Usual Occup	pation	1	6b. Kind of Busin		
within then then then then then then then the	(Specify only highes Elementary/Secondary (0-12) 12		5+)	Give kind of work done ife. DO NOT use retire Omemaker	during most of work d)	ing	Own Hon	n A	
al Hygie other i vent,		.ast)	11	Omemaker	18. Mother's Name	(First, Middle, M			
d 2 should be filed the and Mental Hyg 7 is marked othe treumatic event, TO Be C	Manager and Manager				Tracella	0. (Tn	skeep)		
2 should be to and Mental of marked of sumatic eve	19a. Informant's Name/Relations		19b. F	Mailing Address (Street		7-20		ate, Zip Code	a)
	Donald A. Still			Greene St					
-985	20a. Method of Disposition	wagon nus		Disposition (Name of crematory or other pla		1	20c. Location - Ci		State
Pages net of I int: If Ite iry or o	1 Burial 2 Cremetion		cemetery,	crematory or other pla	1				
rtant njury	4 Donation 5 Other (Sp		Cumber	land Crema 22. Name and Addre		02/22	Cumberla	and, M	D
permit. Pages Department of Important: If I any Injury or phes.	21. Signature of Funeral Service I	A. A. M.	upalls	Scarpelli Cumberlan	Funeral	Home, P.	Α.		
hysician	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one pause on each	d the death. Do no line.	t enter the mode of dyi	ng, such as cardiac	or respiratory erre	est,	Inter	roximate rval Between set and Death
/Medical	Immediate Cause (Final		SEPTIL	SHOUL				1	Dar
Examiner	disease or condition resulting in death)	8.	Due to (or es a co					13	0
<u>ē</u>			Due to (01 es s cc	risequence ory.				1	
flicate be executed 3 physicien and as the bunal-transit edical Examiner	Sequentially list conditions	b	Due to (or es a co	nsequence of):				1	
exec en an rial-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								
physicles the bu	that initieted events	C	Due to (or as e co	nsequence of):					
0 60	resulting in deeth) Lest	d.							
The law requires that the death certified has been signed by the attending page 2 should be detached for use a Completed by Physician/M	Part II. Other significant condition		but not resulting in t	he underlying cause gir	ven in Part I.	23b. Did to	bacco use contr	ribute to the	cause of deat
by the	CCUCAC							☐ Probably	
igned to be det		EFFUENTA	with 9	47 HUNET 10	N				
been sig should b	CARSIVI HYPUPITUM	morally				24a. Was ar		availabl	utopsy findings le prior to tion of cause
	PHYPUPITUM	MRISM				1 ☐ Ye	8 2 No		s 2 No
ysician: In is certificate director, pag	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	e)		
S 0 0	1 Yes 2 No		ient 2 ER/Outp	atient 3LI DOA					
Attending Ph or death. ector: After thi by the funeral	27. Manner of Death 1 Naturel 5 Pending 2 Accident investig		ury ay Year) 28b. Tir Inj		OA Other 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No				
Laf or Attending P Is after death. Mat Director: After t ed in by the funers Certification:	3 Sulcide 6 Could r 4 Homicide determ			28f. Location (St. City or Town	reet and Number o, State)	or Rurai Rou	ite Number,		
to the respirat or Attending within 24 hours after Director; After completely filled in by the fune Medical Certification		g Physician: To the best examiner: On the basis of and manner s	of examination end/						
thin thin the sample		and mainers	www.	29c. Licens	se number	25	9d. Date signed ((Month, Dav.	Year)
	and the or certifier	Hem							
7		1480			26907		EBRUARY		
MUS State Registrar	30. Name and address of person Hary + Sudny 31. Date filed (Month, Day, Year) FEB 2 3 1	who completed cause of MAD = 925	deeth (Item 23a) (T 1315hup trer's Signature			mberla	ndM	100	1500

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** ELEANOR RUTH SMITH FEBRUARY 20 1999 9:10AM · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Allegany Cumberland Sacred Heart Hospital If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Mar 29, 1910 215-20-6029 88 PA Director Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10s. State 10b. County harra 23a or 28a-f short inst must be notified at 1 Yes 2 □ No Director Allegany Cumberland 10f. Zip Code 10c. Citizen of What Country? 10e. Street and Number 1123 Virginia Avenue 21502 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 8 1 Yes 2 No Specify Specify: à 3 Widowed 4 Divorced white "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene, other than Elementery/Secondary (0-12) College (1-4or 5+) lab technician Memorial Hospital 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H is marked off Be James W. Minerd Minerva J. Bodkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If feet 27 is: ury or other trau Nadine Reinhart 12418 StoneyBrook Lane NW; LaVale, MD 21502 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park Cumberland, MD 02/23 22. Name and Address of Facility 21 Signature of Funeral Service Licenses Scarpelli Funeral Home, P.A. Cumberland, MD 23a. Part 1 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** septic shock 12 houts /Medical Immediate Cause (Final disease or condition resulting in death) Examiner 4 hours ON ON MONIN Examine () VIQ daath certificate be asscuted physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) as use jo signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given In Part I. 1 | Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed peen completion of ceuse of death? paga 2 has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mander of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after deatl Director: the 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide 24 hours 29e. Certifier Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated. edical completaly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only To the To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier FEBRUARY 2 0 1999 10 eted cause of death (Item 23a) (Type, Print) 30. Name and eddress of person who cor 144 ANGER MIN HAZON DD CUMBBLUAND UN NYLI)

Registrar **DHMH 16 Ray 6/95**

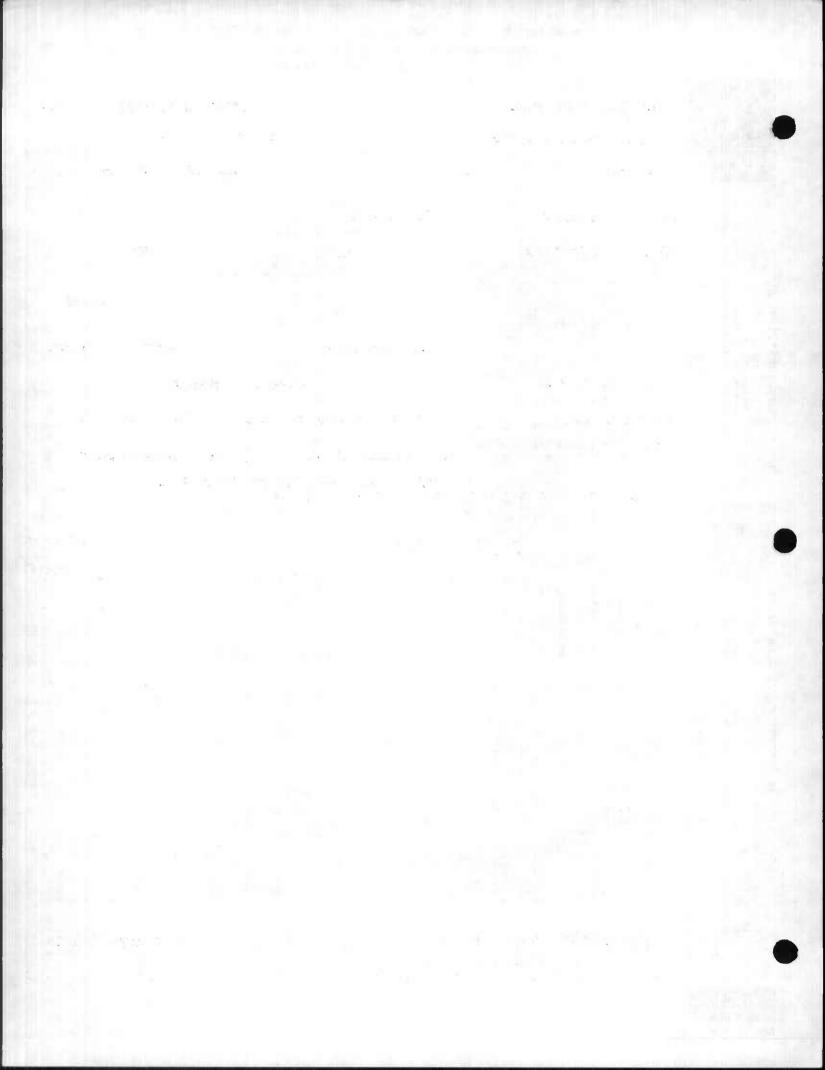
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31. Date filed (Month, Day, Year)

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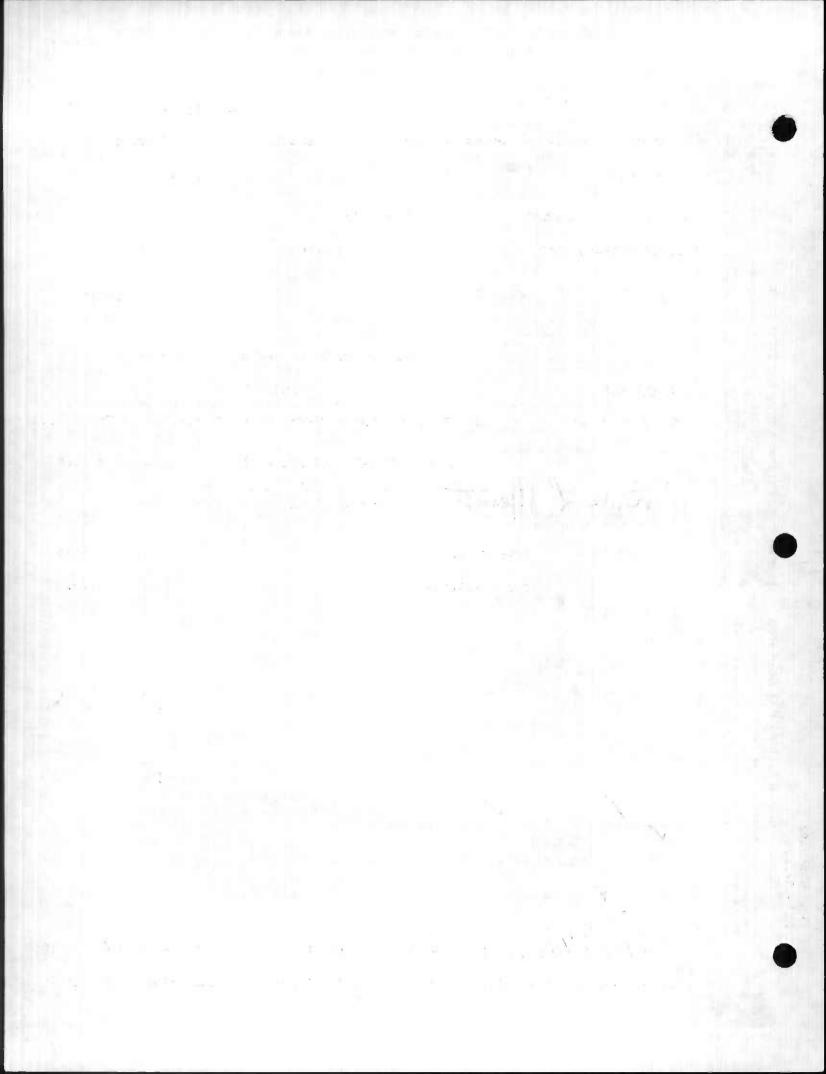
32. Registrar's Signature



		State of Marylan	d / Department of I Certificate of	Health and Mental H	ygiene 9 9	07334
Physiologic	1. Decedent's Name (First, Middle, La			2. Date of D Month	eath Day	3. Time of Death
Physician /Medical		NHOLTZ		Februa		
Examiner	4a Facility Name (If not institution, giv		TAIT TO A STATE OF	4b. City, Town, or Location of Dea	,	
	Memorial Hospita		7	Cumberland	Allega	
Funeral Director	5. Social Security Number 6. S 217-10-7071 Usuat Residence of Decedent	ex	Vrs. If Under 1 Year Months Days	Hours Min. (Month, L	lirth Day, Year) 8 1915	9. Birthplace (State or Foreign Country) PA.
a tand	10e. State 10b. County	10c. Cit	y, Town or Location			10d. Inside City Limits
the Marylar 28a-f show notified at	MARYLAND ALLEG	ANY	CUMBERLAND			1 ☐ Yes 2 ☐ No
d 21215-0020 filed within 72 hours effer death with the Maryland typiene. ther than "natural", or items 23a or 23a4 show int, the Wedical Examiner must be nouned at	10e. Street and Number 12119 BEDFORD ROA	D	10f. Zip Code	21502	10g. Citizen of W	
020 urs effer death alt, or frems 2 Evanioner mu	11. Marital Stetus 1 Never Married 2 Married	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give		Hispanic Origin? (Specify Yes or Noen, Mexican, Puerto Rican, etc.) Specify:	Bleck	- American Indian, c, White, etc.
Dozens Surs	3 Widowed 4 □ Divorced	Year or Dates:	1 ☐ Yes 2 ₹ No	эреспу.	Specify:	WHITE
ind 21215-0020 be filed within 72 hours eff tal Hygiene. d other than "natural", or event, the Medical Exert Recompleted by E	15. Decedent's Ed (Specify only highest gra Elamentery/Secondary (0-12)	ducation de completed) Cotlege (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	during most of working	16b. Kind of Bu	sinass/Industry
nd 21 nd 121 nd 21 other th	8		CELANESE CORE	OF AMERICA 18. Mother's Name (First, Midd)	SUPERVI	
Band be fill He doth	17. Father's Nama (First, Middle, Last)				e, Maigen Sumame	3)
arylan should be nd Mental merked o	ROBERT RISING 19a, Informant's Name/Relationship (Time Print)	10h Mailles Address (Street	MAUDE CLITES of end Number or Rural Route Num	ther City or Town	State Zin Code)
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Jore, M ges 1 and 2 tr of Health if them 27 is	20a. Method of Disposition	20b. P	lace of Disposition (Nema of	Dete	7	City or Town, State
non ages ant of y or o	12 Burial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Othar (Specif	JRemoval from State	emetery, cremetory or other plant		CIMPEDI	AND MARYLAND
Baltimore, pemit. Pages t an Department of Heal Important: if New 2 any injury or other and.	21. Signature of Funeral Service Liger		N MEMORIAL PAI		COMBERLA	AND MARIDAND
Bal Demii Deparii Impo	HA 1. 4	Mart		DAMS FÜNERAL HOM		TT ABYD
	23a. Part1. Enter the disease, or com shock, or haart tailure. List only	ptications thet caused the deat		JR STREET CUMBER		Approximate
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/Medical Examiner	Immediate Cause (Finat disease or condition resulting in death)	a CHRONIC CHF	r as a consequence of):			1 YEAR
	5	RENAL FAILUE				2 WEEKS
760, te be executed ysician and he burial-transit	Sequentially tist conditions, it any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury	b	r as a consequence of):			
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P.O. hat the d by the deteched	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying cause g		Yes 21 No	atribute to the cause of death? 3 Probably 4 Unknown
al Records, The law requires to cate hes been signer, page 2 should be to completed by				24s. Wi	as an autopsy rlomed?	24b. Wera autopsy findings available prior to completion of cause of death?
II Rec				11	Yes 20 No	1 □ Yes 2 □ No
Vital I	25. Was case referred to medical			y one)		
- S & -	examiner?	Hospital: 1 Inpatient 2 [ER/Outpatient 3[] DOA	ther: 4 Nursing Home 5 Re	sidence 6 Oth	er (Specify)
Ltz Itz	27. Manper of Death 1 Naturat 5 Pending 2 Accident investigatio		28b. Time of Injury M 1[ury at 28d. Dascrib ork?] Yas 2 No	e how injury occurr	ed
7a Shanholtz [7-10-707] Division C Prospital or Attending Pl 24 hours after death. Funeral Director: After it etely filled in by the funeral certification.	3 Suicide 6 Could not be determined		ome, farm, street, factory, office y)		(Street and Numb Fown, State)	er or Rurel Route Number,
7-17-11 Hospit Hospit St. Houspit Funer February fillers of the Hospital Ho	29a. Certifier 11 Certifying Ph (Check only one) 2 Medical Exar			time, data and place, and due to to opinion, death occurred et tha tim		
Ev 21 To the within 2 To the comple	29b. Signaful et and title of Centifier	James W	29c. Licer D160	nse number 041	29d. Date signed February	(Month, Day, Year)
not	30. Name and addless of person who			cal Ruilding Cu		MD 21502

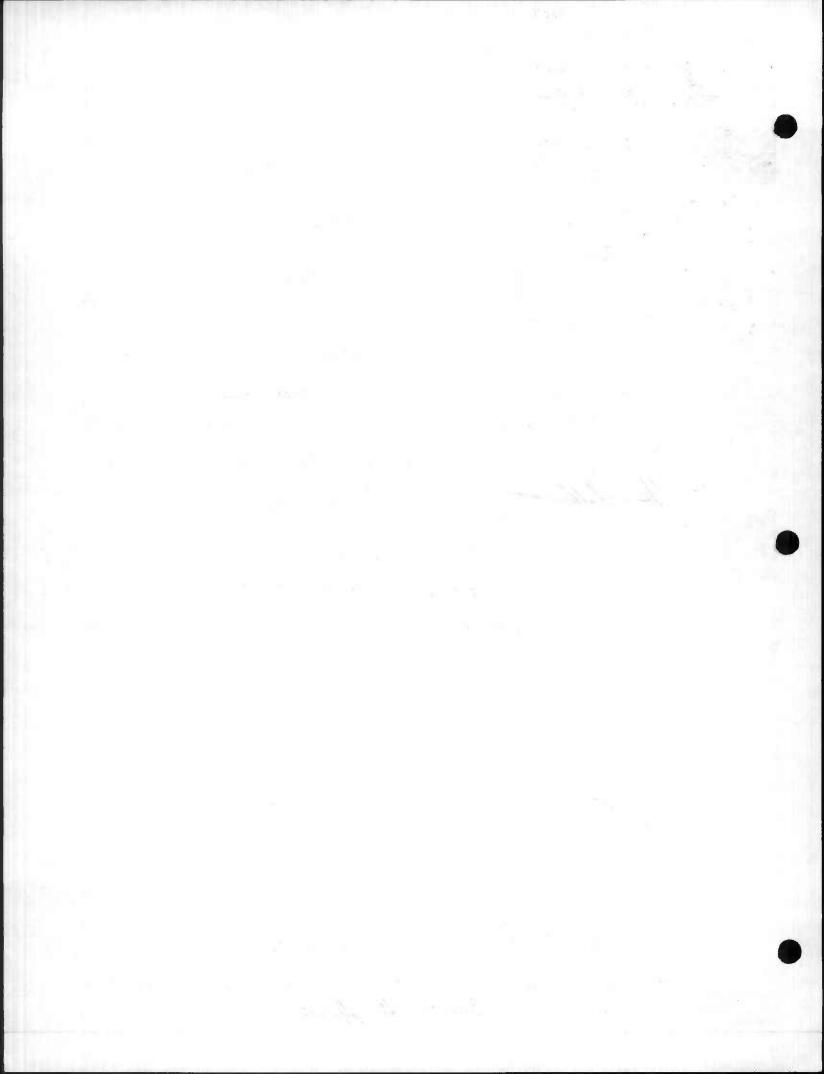
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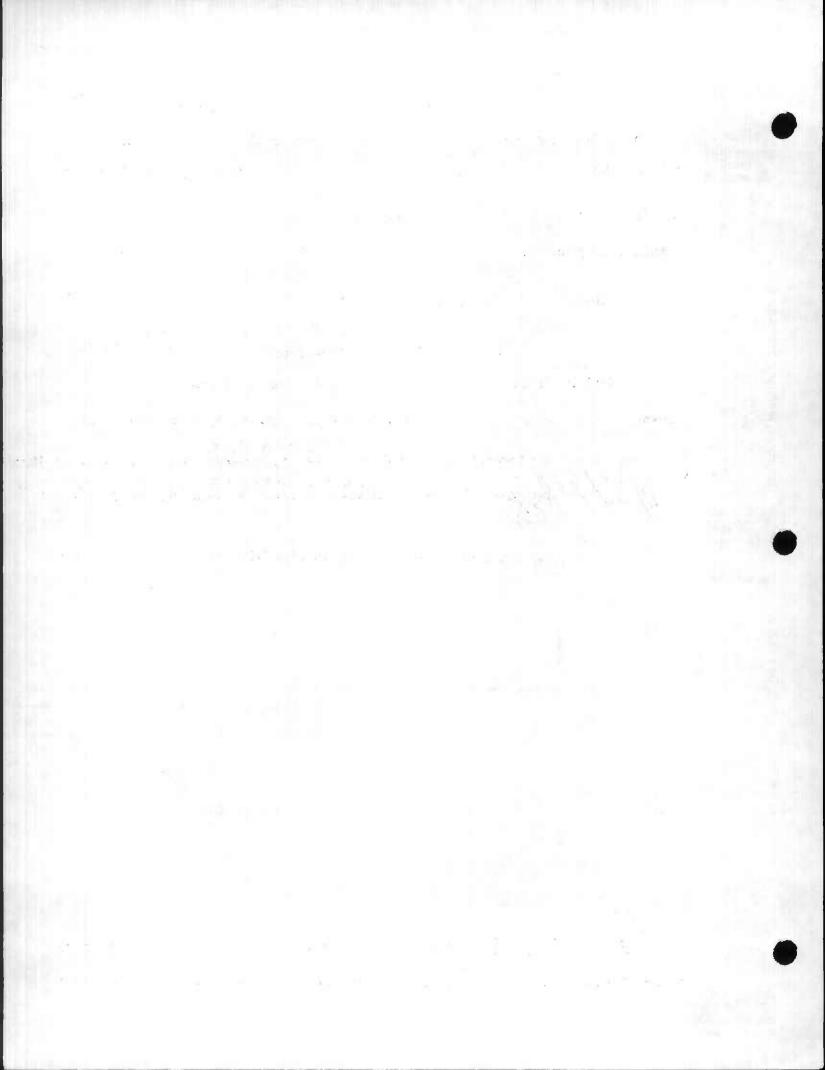
						τιτιca					Reg. No.		
Physic	ian	Decedent's Nama (First, Middle, La								2. Dete of De Month	eth Day	Year	3. Time of Death
/Medi		Joseph Julian		iller						Feb	1	1999	2:25AM
Exami	ner	4a. Facility Nama (If not institution, giv	e street and number)				4b. City, To	wn, or Loc	cation of Daat	4c. Cour	ity of Death	
		Genesis Elder	Care - T	he Pi	nes				ston		Ta	lbot	
Funeral		5. Social Sacurity Number 6. S	Sex 7.A XOM 2□F	ge (In yrs. las	of birthday) Yrs.	Months	r 1 Yaar Deys		Min.	8. Date of Bir (Month, De	th y_Yeer)	9. Birth	pieca (Stete or Fore
Director		214-16-4005 Usuei Rasidence of Decedent		93	TIS.				-	sept.	5, 19	95 K	ennedyvil
and W		10a. Stete 10b. County		10c. City,	Town or Loc	cation							10d. inside City Lim
the Marylar 28a-f ehow notified at	ŏ	Maryland Kent				Cho	ator	town					1 ☐ Yes 2√€)(
the 289	Je C	10e. Street and Number		1		1	p Code	LOWII			10g. Citizen d	f What Cou	ntrv?
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s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23s or 28s4 show other traumatic event, Ite Medical Evantines must be notified at	Funeral Director	11. Maritai Status	12. Wes Deceden	t Ever in U.S.	13. V			Hispanic Ori	ain? (Spe	cify Yes or No	U.S.	A . ece - Ameri	can fndien.
r Her	Fur	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ☒						, Puerto F	cify Yes or No Rican, etc.)	В	leck, White,	
urs a	by	3 ₩idowed 4 Divorced	If Yes, Give Yeer or Detes		1	□ Yes	2 ₩ No	Specify:			Spec	elfy: Bla	ack
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certificate rector, pag		25. Was case referred to guedical						nn Nice	of Doub			1 1	□Yes 2⊡TNo
Physician: this certific ral director,	o Be	examiner?	Hospital:	affer			Ot Of	har		(Check only	200		
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Pre din t	ert	4 ☐ Homicide determined	building, e	fo. (Specify)						City or To	en, State)		
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To the Hospital Within 24 hours & To the Funeral I completely filled	Σ	30. Nama and address of berson who ANIEL E. M.F. 31. Deta filed (Month, Day, Year) FFR 2 6		down (Item 2	3a) (Type, F				-	EAST	2/17	7/99	16.01



State of Maryland / Department of Health and Mental Hygiene 99 07336

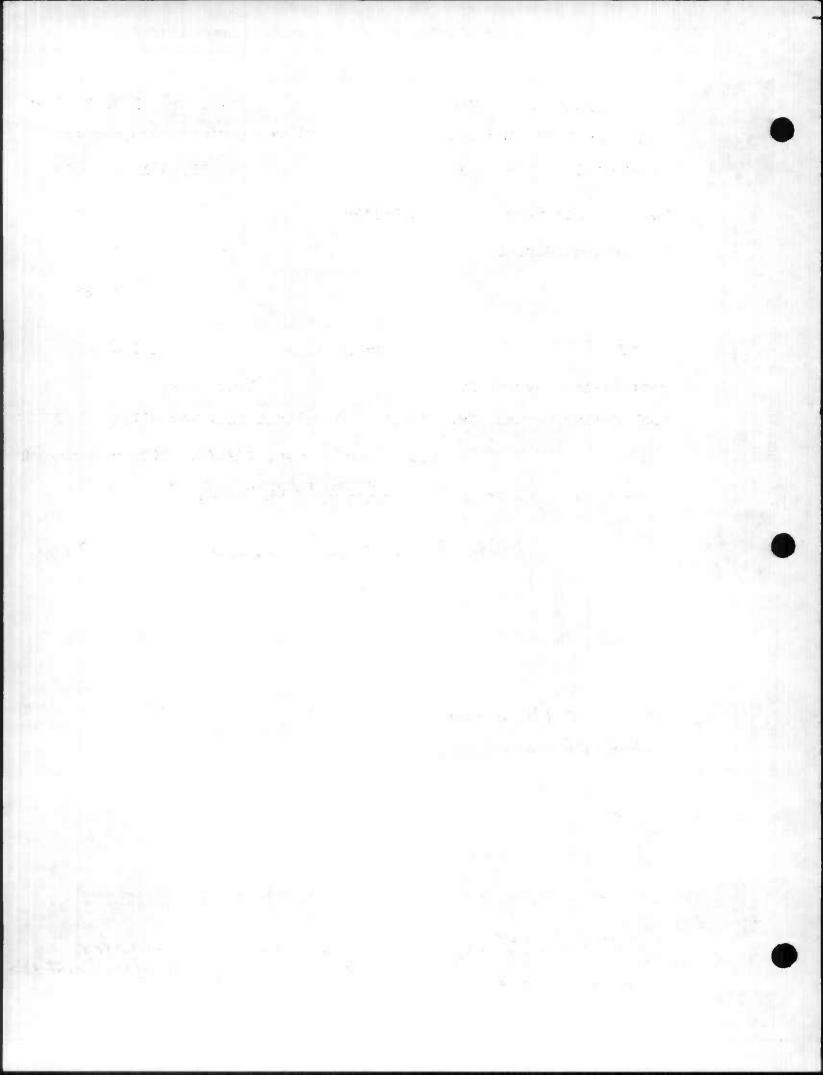
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Vincent J. Tost February 25, 1999 12.37 AM Security Name (front institutor, your street manufact) 6502 Ellington Way 6502 Ellington Way 67. Age drys. and formout) 6502 Ellington Way 100. State 100. Conty 100. State 100. State 100. Conty 100. State		1. Decedent's Neme (First, Middle, La	est)					2. Date of De	eth	Veer		
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\$ 50000 Security Numbers \$ 50000 Security N		4e Fecility Neme (If not institution, gi	ve street end number)			4b. City, Town, or	Location of Daat	h 4c. Count	y of Deeth		
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10. Commy 10.	Funeral Director	127-20-6963			Month			(Month, De				or Foreign
Maryland Frederick Frederick 10/2 pCode 10/2 Cities of What Country? 10/2 pCode	3			10c City Tow	m or Location					10	d Inside C	ity I imits
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Susan L. Trost/Daughter 12407 Hill Court, Mt. Airy, Maryland 21771	To	Carl P.	Trost				Marg	aret She	eehan			
1 Buriel 2 Oremetion 3 Removal from Steles	un.	19a. Intorment's Name/Reletionship	(Type, Print)	198	o. Meiling Addre	ess (Stree	et end Number or Ri	ural Route Numb	er, City or Town	n, State, Zip	Code)	
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A Donation Sixty Sixty Committee	fg.		70	20b. Plece o	of Disposition (form), crematory of	Veme of or other pl	ece) Fobrace	Dete	20c. Location	- City or Tov	vn, Stete	
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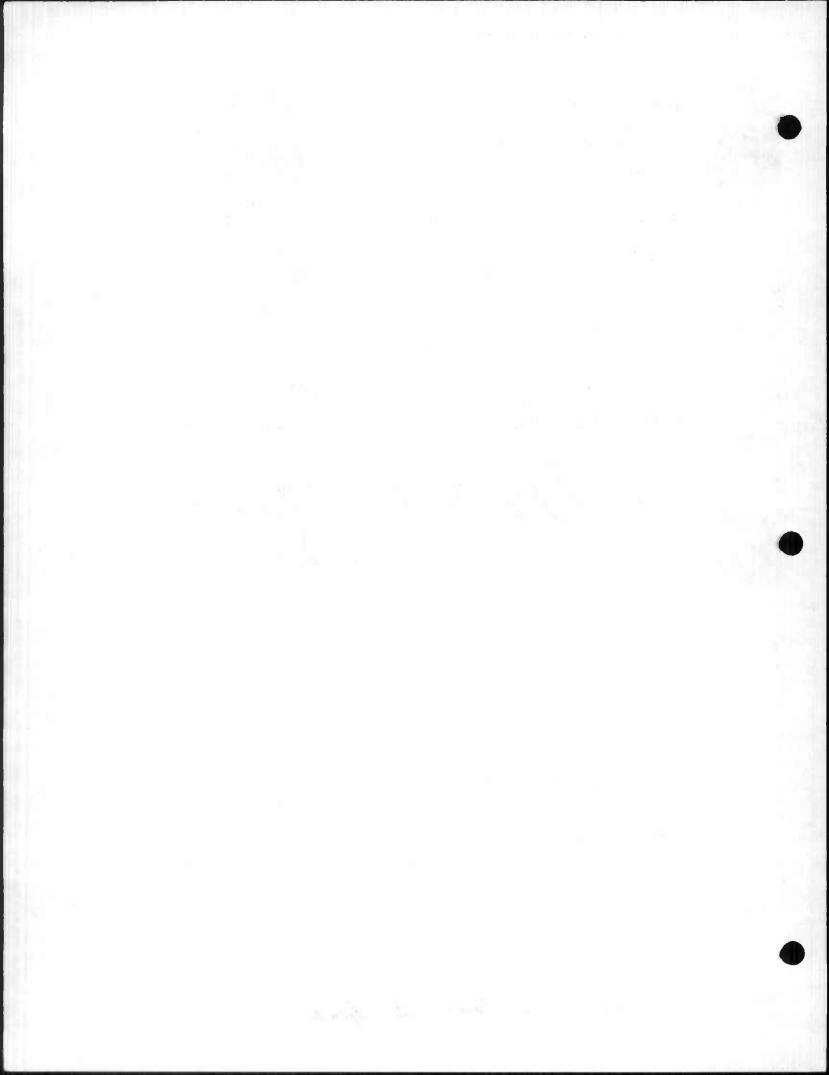
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/Medical	4a. Es allihu Nama (lé pat insti		VYMAN		4b. City, Town, or	FEB .			7:00 AM
Examiner		ok Nursing				Spring		ITGON	MERY
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Division To the Hospital or Attending I within 24 hours effer deeth. To the Funeral Director: After completely filled in by the funer Medical Certification		tifying Physician: To tha b lical Examiner: On tha bas and manna	sis of axaminetion a	nd/or Investigation, in m	ny opinion, daath occ	e, and dua to the curred at tha tima,	data and placa,	and dua to	tha causa(s)
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State Registrar	FEB 2	(ear) 32. Ra	gistrer's Signetura	B. Spar	K				



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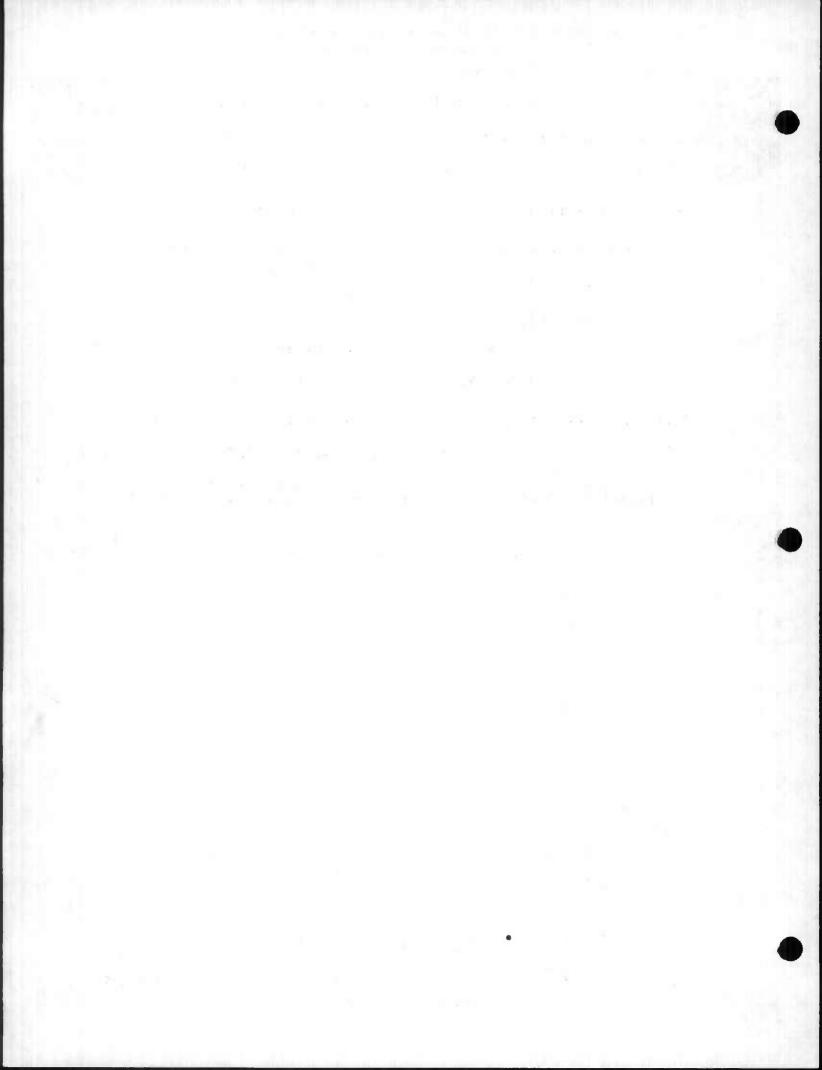
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/Media		Wendell Holmes Ta	ylor									Febru	ary 22	, 1999	1:50a.m
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Funeral		5. Social Security Number	6. Sex		7. Age (/	n yrs. lest birtl	hday)	If Under	r 1 Yaar Deys	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D			nplece (Stete or Forai
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		Usuei Residence of Decedent													
ahow	_	10a. Stata 10b. Coul	nty		10	c. City, Town	or Loc	ation							10d. Inside City Limi
1	cto	Maryland Kent	t			Rock 1	Hal:	1							1 ☐ Yes 2 ☐ N
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al', or items 23a or 28a-f ahov Examiner must be notified at	Funeral	11. Marital Status	12.	. Was Dec	cedent Eve	r in U,S.	13. W	as Dace			gin? (Sp	ecify Yes or N Rican, etc.)	0- 14. [Rece - Amar	
or it		1 ☐ Navar Married 2 W	larried		2 X No			☐ Yes		Specify:		rticari, etc.,		Black, White	
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Phys	ician		23a. Part1. Enter the diseasa, or complishock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do	not enter the m	OX 43 node of dyln	B, Feder	a 1 S D U r or respiratory ar	rast,	2103	Approximate Intervel Between Onset and Deeth
	dical		Immediate Ceuse (Final disease or condition resulting in death)	Conv	ica/	My	1/0p	17/14				Months
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68760, ifficate be executed	niel-trans	Examiner	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	S	Due to (or as e	consequenca	of):				1	
	for use es the bunel-transit	Medical	Cause (Disease or Injury thet initieted events resulting in death) Last		Dua to (or as a	consequence o	of):					
O. Box	for us	clan							1		Î	
و ق	be deteched	by Physician/N	Part II. Other significant conditions con	ntributing to death bu	ut not resulting	in the underlyIn	g cause glv	en in Part I.		tobacco use cor Yes 2 No	3 Prob	the causs of deeth?
Corc	2 should be	Completed b								an autopsy med?	ava	re autopsy findings allable prior to appletion of cause deeth?
The H	page 2	Com							101	res 2ENo	1	Yes 2E No
of Vital Physician: Th	octor	Be	25. Was case referred to medical examiner?	1				26. Place of Deeth	(Check only o	00)		
- 5 4	0 0	2	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1		outpatient 3		4 LI Nursing Hor				9
Division or Attending a	the funer	Certification:	1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	Year)	Time of Injury M		Yes 2□No		now Injury occurr		
DIVI	lled in by		4 Homicide determined	28e. Pleca of Inju building, etc	(Specify)				City or Tou			
Division Of Tothe Hospital or Attending Phythin 24 hours efter death.	pletely f	ledical	29e. Certifier (Check only one) 1 Cartifying Physical Exernity one)	sicien: To the best oner: On the basis of and manner sta	examination at	e, deeth occurre nd/or Investigati	ed at the tin on, In my o	ne, dete and placa, a pinion, death occurre	and due to the ded et the time,	causa(s) and ma date and place, (nner as stand due to	ated. the cause(s)
Tot	00	2	29b, Signature and title of certifier	She	mm		29c. Licans			29d. Date signed Z/Z		,
			30. Name and address of person the co	lipleted cause of de	eath (Item 23a)	(Type, Print)	T-A	31466 Durchm	aul au	« KACT	a kn	121100
	Stat	е	31. Date filed (Menth, Day, Year)	QQQ 32. Registe	r's Signeture	4	lon	11		16.111	7.7	0.09



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8:00 P.M. LAKE E. VIOLETT FEBRUARY 18, 1999 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Months 1□ M 2√F Yrs 577-46-9825 98 SEPT. 28, 1900 VIRGINIA Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Directo MONTGOMERY 28a-f BETHESDA 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? b 6530 DEMOCRACY BLVD. Лети 23а 20817 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Bleck, White, etc. 1 X Yes 2 Now WI If Yes, Give Year or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: WHITE Š 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY U.S. GOVERNMENT Department of Health and 2 should be like Important: If Item 27 is marked other any injury or other by 18. Mother's Neme (First, Middle, Maiden Surneme) 17 Father's Name (First Middle Last) Be LAKE WEBSTER JONES SARAH STEELE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7500 GREENWAY CENTER DR., GREENBELT, MD 20770 19a. Informent's Name/Reletionship (Type, Print) DALE JERNBERG ATTORNEY 20a. Method of Disposition 20b. Plece of Disposition (Name of Date 20c. Location - City or Town, State FAIRFAX CEMETERY 1 X Burial 2 Cremetion 3 Removel from Stete 2/23/99 FAIRFAX, VIRGINIA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility

JOSEPH GAWLER'S SONS, INC, 5130 WISCONSIN AVENUE 21. Signature of Funeral Service Licensee WHI NW, WASHINGTON, D.C. 20016 blications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, one cause on each line. Approximete Interval Between Onset and Death disease, or com **Physician** /Medical Immediate Cause (Finel days Dreumonia disease or condition resulting in death) piration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? esophagitis with bleedin 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1□ Yes 28 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Furneral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the To To the To the F 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier MI 2-19-99 D20297 Done

State Registrar MD

strar's Signeture

4701 Willard Ave. Chery Chase and 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brodsky

32. Rep

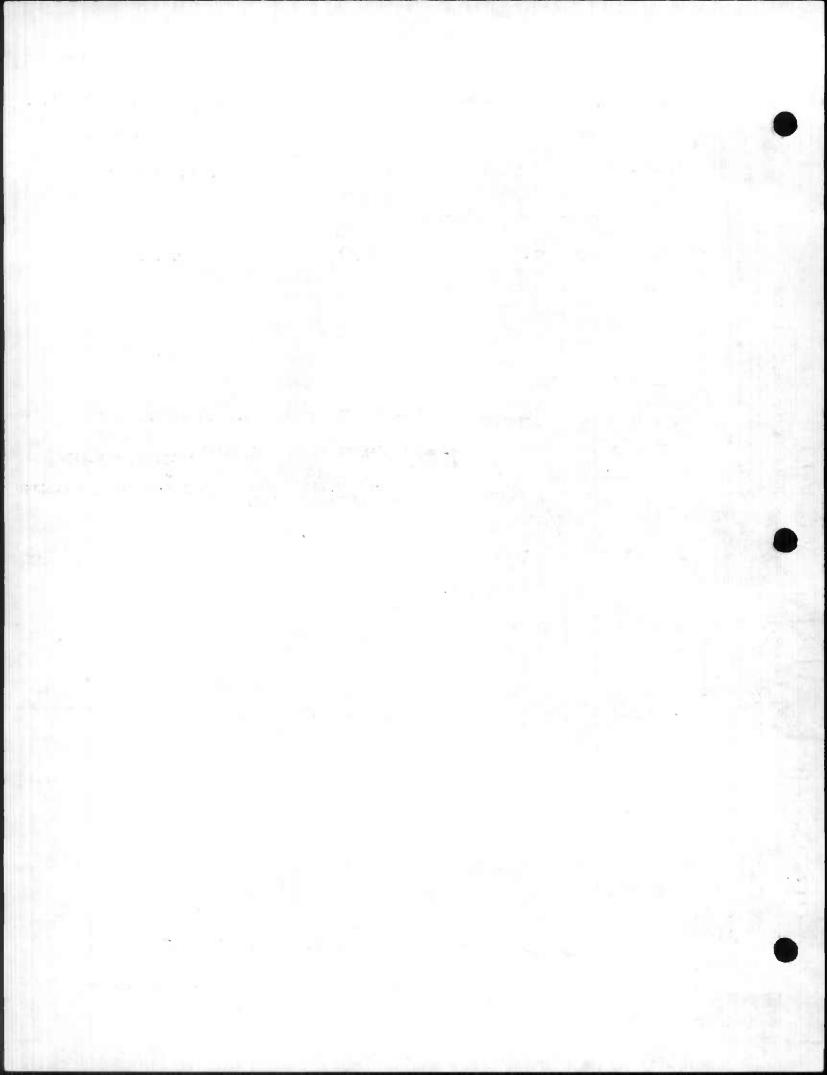
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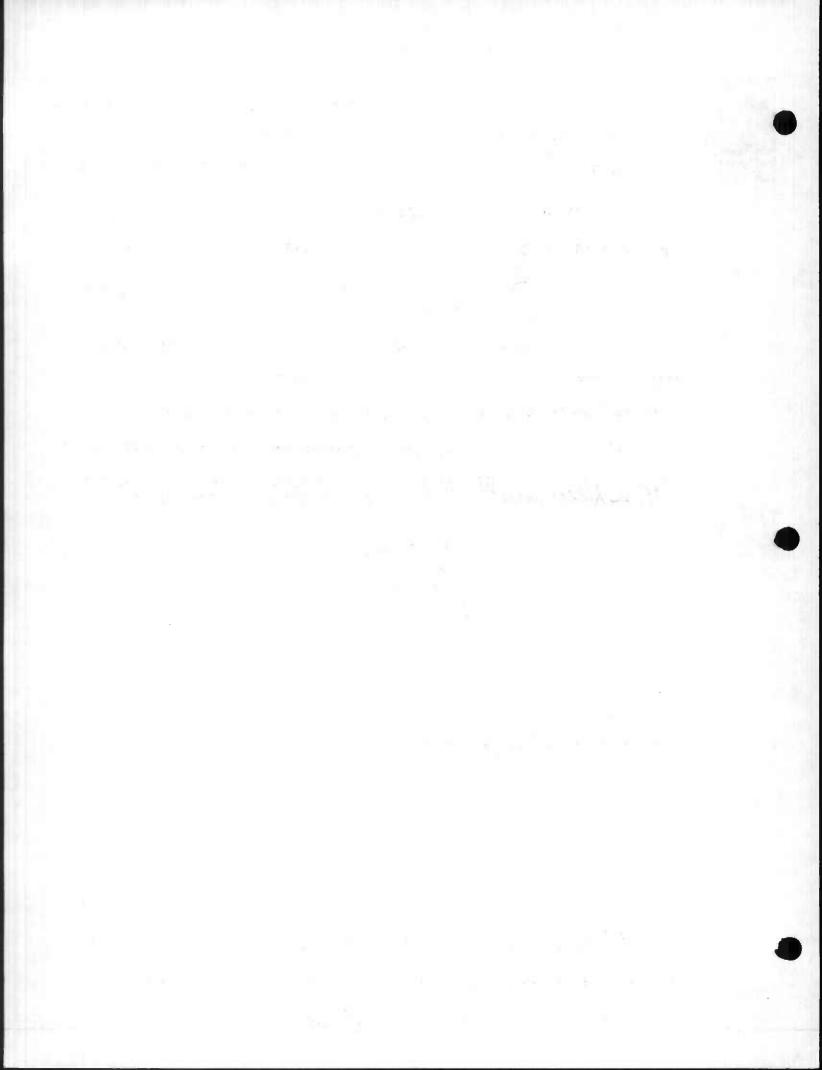
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31. Dete filed (Month, Day, Year)

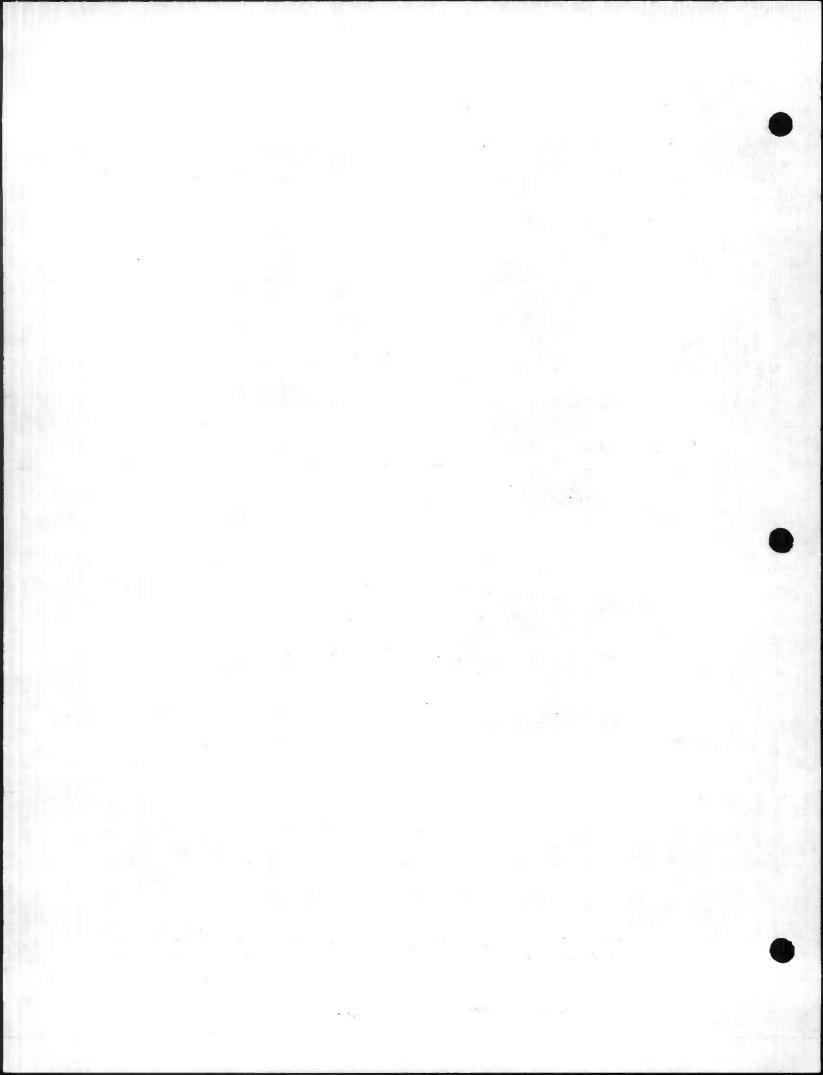


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To Be	5 .		TUCK							MARY		ANG			
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	_	CATHERINE '		TUCK /W.	LFE					LANI	1, E				
	206	 Method of Disposition Burial 2XXCre 		☐Removal from	n State	20b. Pled cem	oe of Dispos	sition (Nam letory or ot E CDE	ne of ther place MATT	ON CT	פיז	Dete	20c. Location -	City or Tov	wn, State
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SUCO	21	. Signeture of Funerel	Selvice Lice	nsee	西。	- 55	P FE	Neme end	, HE	LFENI	BEIN	& NEWN	AM FUNE	10d. Inside City 1XC Yes 2 3. Citizen of Whet Country? USA 14. Race - American Indian, Black, White, etc. Specify: WHITE 3b. Kind of Business/Industry INSURANCE Siden Sumame) City or Town, State, Zip Code) 2 1601 3c. Location - City or Town, State STEVENSVILLE, MD 4. FUNERAL HOME, P MD 21601 4. Approximate Interval Between Conset and December 1985 3. Approximate Interval Between Conset and December 1985 4. Approximate Interval Between Conset and December 1985 3. Approximate Interval Between Conset and December 1985 3. Approximate Interval Between Conset and December 1985 4. Approximate Interval Between Conset and December 1985	OME, P.A.
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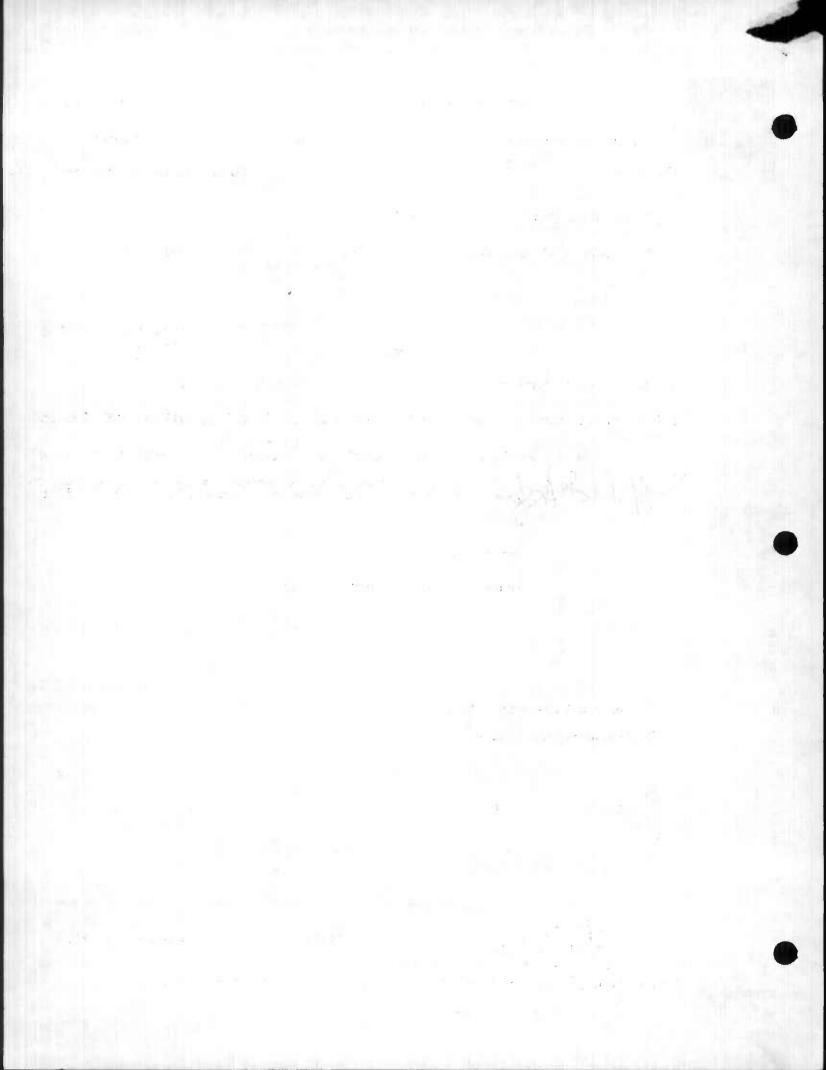


				State Of IVI	arylallu /	Certificate of			leg. No.	07	342
			1. Decedent's Name (First, Middle, Lu	nst)				2. Date of Dea	th		3. Time of Death
	Physicia /Medic		Martha Elizabet	h WILKINSO	N			Month Februar		Year 1999	2015
	Examin		4a Facility Name (If not institution, gir	ve street and number)			4b. City, Town, or	Location of Death	4c. County o		
	3		Washington Coun				Hagerst		Washi		
	Funeral Director		216-22-9615	Sex 1 □ M 2 □ X F	e (In yrs. last bi	Yrs. If Under 1 Yeer Months Days				9. Birthpla Countr Mary	ace (Stete or Foreign ry) Land
	P 2 10		Usual Residence of Decedant 10a. State 10b. County		10c. City, Tov	vn or Location				10	d. Inside City Limits
	ith with the Maryla 23e or 28e-f sho wat be notified at	tor	Maryland Washin	oton	н	agerstown					1 No 2 No
	or the	Director	10e. Street and Number	5011		10f. Zip Code			10g. Citizen of W	hat Counti	ry?
	23a dila		11 W. Baltimore	Street		217	740		U.S.A	Α.	
020	rs after dea	by Funeral	11. Menitel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 XI If Yes, Give Year or Dates:		13. Was Decedent of Market Yes, specify Cub	en, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		- America , White, et Whi	tc.
Maryland 21215-0020	72 hou		15. Decedent's E		16a	Decedent's Usual Occup (Give kind of work done	pation	ndina	16b. Kind of Bus	iness/Indu	ustry
21	and and	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	College (1-4or 5		life. DO NOT use retire	d)	nking			
7	har b		8 17. Father's Name (First, Middle, Last	0		Housekeep:		me (First, Middle,	Hosp:		
and	od be and of seve	o Be	John Thomas Ingr					Virginia		,	
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ore,	of Herrical		20a. Method of Disposition	TENTEL ISI		of Disposition (Name of ary, crematory or other pla		Data	20c. Location - C		
timore	Page nant c		1 M Burlal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special			Hill Cemeter		2/24/99	Hagerst	town,	Maryland
Balt	partition of the same of the s		21. Signature of Funeral Service Lice	nsee	^	22. Name and Addre	ess of Facility M:				
ш	20288		2cott	1/1/11	nacch	415 E. Wi				Mary1	and 21740
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State Registrar Irving Mizus, M.D., 31. Date liled (Month, Day, Year) FEB 2 6 1999



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State of Maryland / Department of Health and Mental Hygiene 0 7 2 1.1.

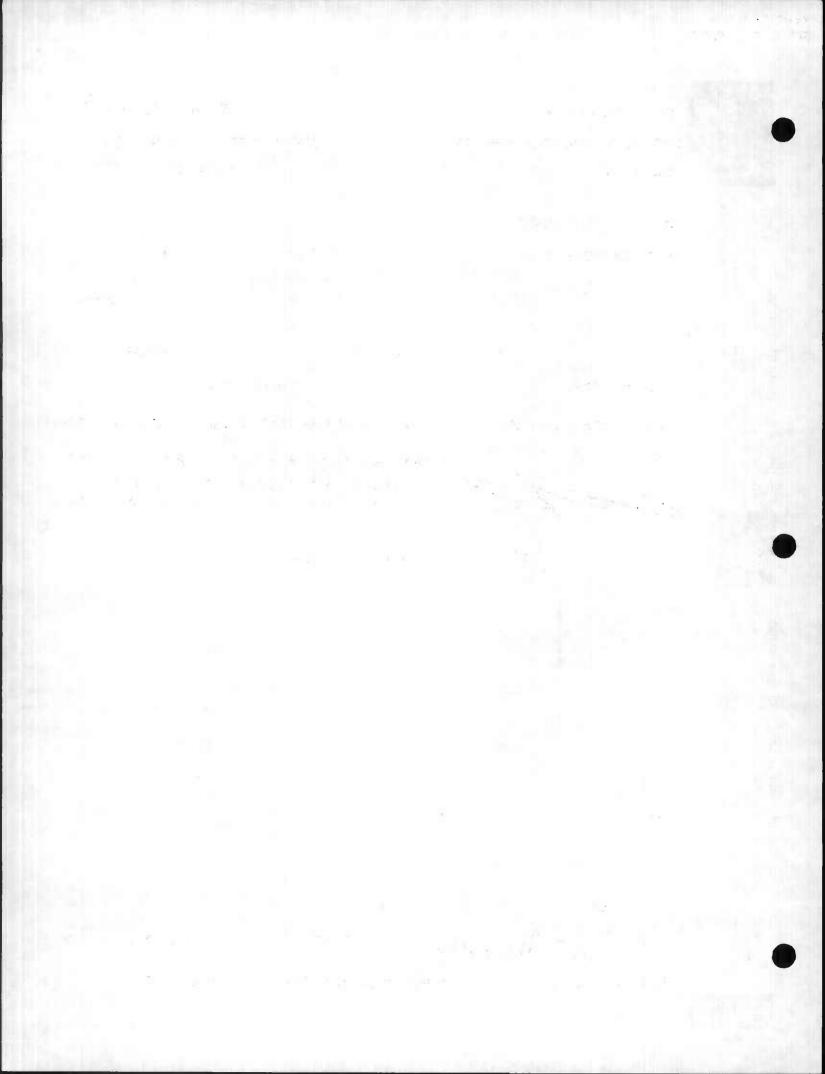
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cian RANDI JOY WAXMAN	J					FEBRU		1850 PM					
4a Facility Nama (If not institution, give	va street and number)				4b. City, Town, or	Location of Daat	h 4c. County o	of Death					
WASHINGTON ADVENT	TIST HOSPIT	TAL			TAKOMA F	PARK	MONTGO	MERY					
	Sax 1 M 2 F	a (In yrs. las 35		f Undar 1 Yay Months Day			1964	Birthplaca (Stata or Foreig Country) PA					
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	LANE				20814		USA						
10302 THORNBUSH I 11. Marital Status 1 Navar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armad Forcas? 1 Yas If Yas, Giva Yaar or Datas:			s Dacedant o as, specify Co Yas 20XN	f Hispanic Origin? (i uban, Maxican, Pua lo <i>Specify:</i>	Specify Yas or Norto Rican, atc.)	14. Raca Black Specify:	- Amarican Indian, s, Whita, atc. WHITE					
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15. Decedant's E (Specify only highast gra Elamantary/Secondary (0-12)	Collaga (1-4or 5	i+)			ired)		PDUGE	DIONI					
	5+		PROFES	SOR	10.11		EDUCAT						
17. Fathar's Nama (First, Middla, Last	"					, ,	, Maidan Sumama	9					
o MORTIMER MAZER						ESTEIN							
19a. Informant's Name/Ralationship ((Type, Print)	1	19b. Malling	Addrass (Stra	at and Number or F	Rural Routa Numb	er, City or Town, S	Stata, Zip Coda)					
RICHARD WAXMAN/HI 20a. Method of Disposition 1 Burial 2 Cramation 3	20b. Place of Disposition (Name camatary, cramatory or oth JUDEAN MEMORIA			ion (Nama of lory or othar p	olaca)	Data	20c. Location - C	City or Town, Stata					
4 Donation 5 □Other (Spacity) JUDEAN MEMORIAL GARDENS 2.19.99 OLNEY, MARYLA 21. Signatura of Funaral Sarvica Licansee 22. Nama and Addrass of Facility EDWARD SAGEL FUNERAL DIRECTION, INC.													
21. Signatura of Funarai Sarvica Lical	nsee /	2	1		AGEL FUNE KVILLE PI								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last	c		as a consequa s a consaqua										
Part II. Other significant conditions of		ut not rasulti	ing in the unde	adving causa	given in Part I	23h Did	tobacco usa cont	tributa to the causa of dea					
Physical	SOTATIONARY TO GOULTE	at not radan	and an area	arry rig occord	gran, mr. arri			3 Probably 4 Unknown					
Completed by							s an autopsy ormed?	24b. Ware autopsy finding available prior to completion of cause of death?					
6						16	Yas 2□No	1 Yas 2 No					
25. Was casa rafarred to madical					26. Place of De	eath (Check only	ona)						
axaminar? 1 XXas 2 □ No	Hospital:	nt 2Ft/El	R/Outpatiant	3□ DOA	Other:			er (Spacity)					
	28a. Data of Inju (Month, Da	ry 2	8b. Tima of Injury	ant 3LI DOA 4LI Nursing Homa 5LI Hasidanca 6 LiOther (Spaciny)									
1 Natural 5 Pending investigatio		ury - At hom	a, farm, straat	t, factory, offic		(Streat and Numbe	ar or Rural Routa Number,						
1 Shatural 5 Pending investigation 3 Suicida 6 Could not be determined		(Spacify)											
2 Accident investigatio 3 Suicida 6 Could not be determined	building, atc	of my knowle exa <i>m</i> inatio	edge, death o	ccurrad at the	tima, data and plac	ce, and due to the	causa(s) and mar date and place, a	nner as stated. Ind dua to tha causa(s)					
29a. Certifier 1 Cartifying Pt	building, atching building atching building building building atching building build	of my knowle exa <i>m</i> inatio	edge, death o	ccurrad at the	tima, data and plac	ce, and due to the	, date and place, a	nner as stated. und dua to tha causa(s) (Month, Day, Year)					
29a. Certifier (Check only one) 29b. Signatura and titla of certifier	hysician: To the best of miner: On the basis of and manner sta	of my knowled examination ated.	edge, death o n and/or invas	courrad at the stigation, in m	tima, data and plac y opinion, death occ	ce, and due to the	, date and place, a 29d. Data signed	ind dua to tha causa(s)					
29a. Certifier (Check only one) 29b. Signatura and titla of certifier	hysician: To the best of the b	of my knowled examination ated.	edge, death on and/or invas	29c. Lice O • C	tima, data and plac y opinion, death occ ansa nu <i>m</i> ber	pe, and due to the curred at tha tima	, date and place, a 29d. Data signed FEBRUARY	I (Month, Day, Year) Z 18, 1999					



Physician /Medical Examiner tha death certificata be executed

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

Funeral

Director

with the Maryland r 28a-f show a notified at

permit. Peges 1 end 2 should be filed within 72 hours after death with i Department of Heelth and Mantel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other treumetic event, the Medical Example must be nonce.

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

attending physician end for use as the bunal-trens 88 USe ed by the a signed by pege

Examiner edicai Physician/M à Completed Be To funeral Certification:

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24 hours

To the Hosp within 24 hor To the Fune complately fi

In by

edicai

Hospital or Attending

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

3 ☐ Sulcide

(Check only

29a. Certifier

5 Pending investigation 28 Accident 6 Could not be determined 4 ☐ Homicide

28a. Dete of Injury (Month, Day Year) FEBRUARY 20, 1999 & 1015 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

BHW BT Homb

28b. Time of Injury

28c. Injury at Work? 1 Yes

2 No

28d. Describe how Injury occurred HANGWY

28f. Location (Street end Number or Rural Route Number, City or Town, State) \$100 factly for O CAYTONS VILLE 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

4 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and pleca, end due to the cause(s) and manner stated. 29b. Signati and title of certifier

OME W.9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 015236

29d. Date signed (Month, Dey, Year) FORUALY 20, 1999

State Registrar

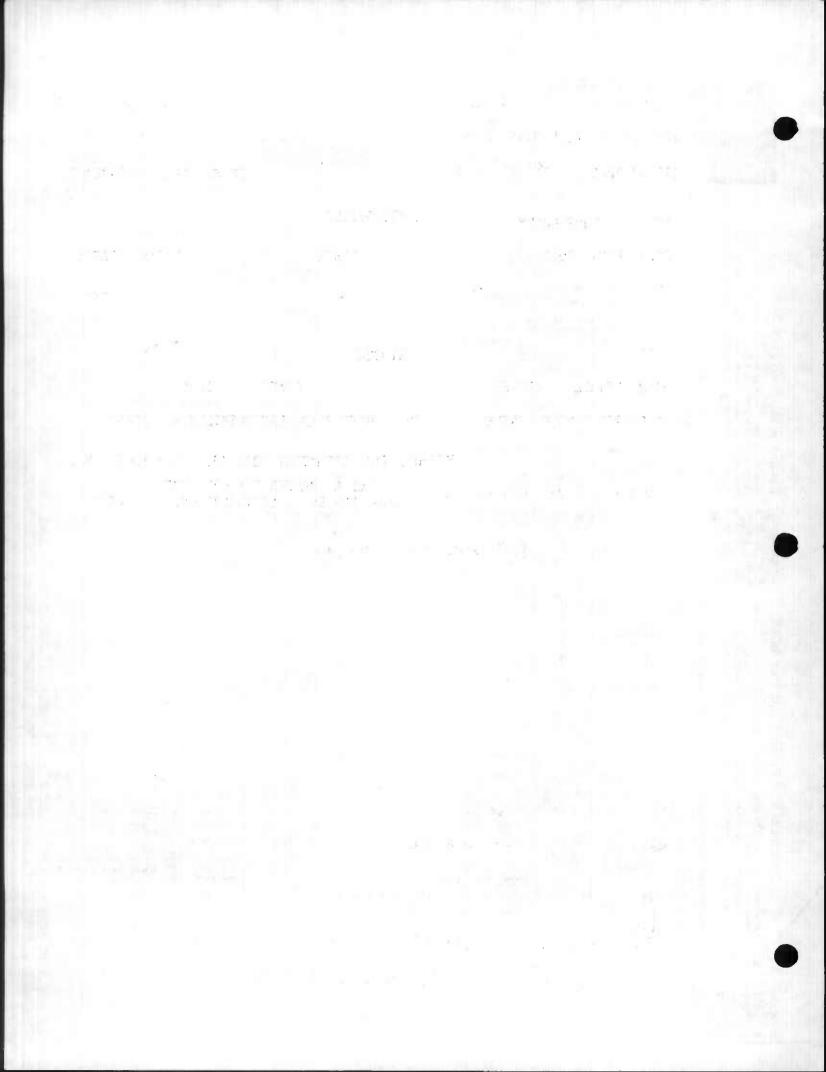
31. Dete filed (Month, Day, Year) FEB 2 2 1999

CARU MARGOUS, MO

(OME 32. Registrar's Signature

11/25 Reakville Bike, Packville, Moro852

DHMH 16 Rev 6/95

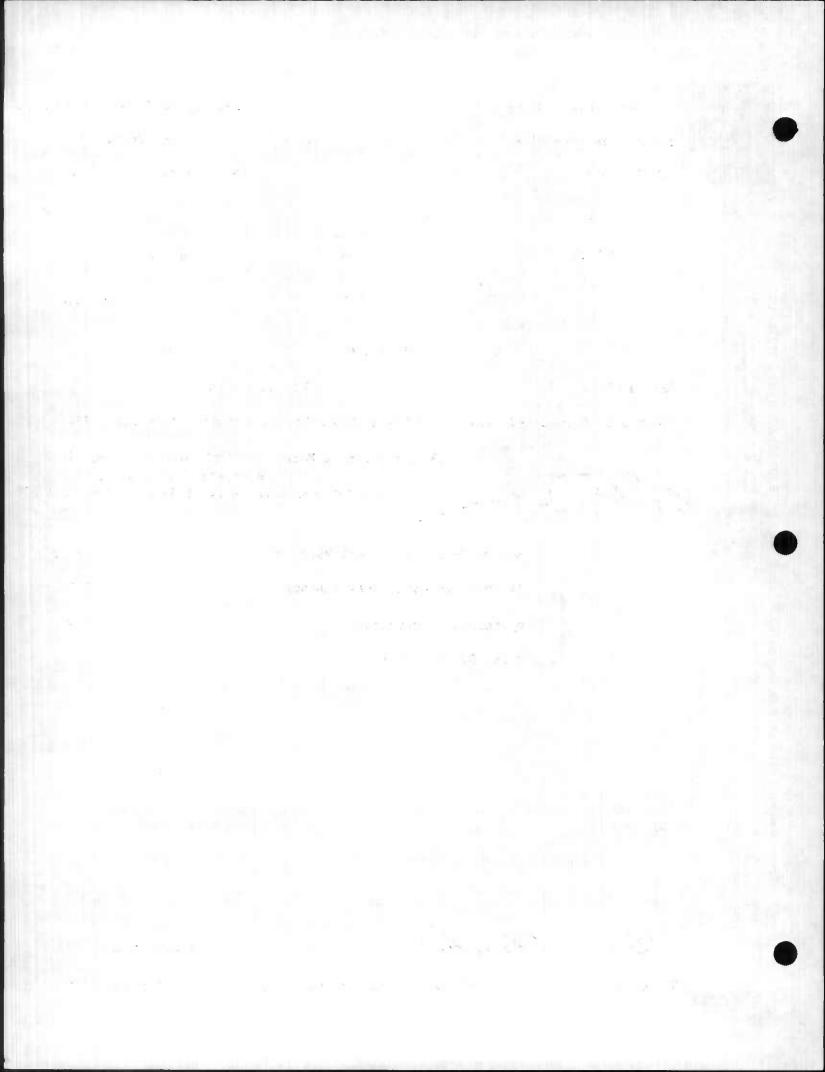


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State of Maryland / Department of Health and Mental Hygiene 0 0731,7

			Cert	tificate of	Death	Re	g. No.	U	1041
	1. Decedent's Name (First, Middle, L	ast)				2. Dete of Death Month		Yeer	3. Time of Deeth
Physician /Medical	Huae-Chen	Whang		85.74		February			7:30 A.M
Examiner	4e Fecility Neme (If not Institution, g	ive street and number)			4b. City, Town, or	Location of Death	4c. County o	f Deeth	
	10808 Rock Run	Drive			Potomac		Montgo	mery	
Funeral Director	5. Social Security Number 6. 220-98-1466 Usuel Residence of Decedent	Sex 1 M 2 XF 7. Age (In yrs. I	last birthday) Yrs.	Months Deys	if Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Nov. 2,1	Year) 918		aca (State or Foreig try) iina
1	10a. State 10b. County	10c. City	, Town or Loc	ation				10	od. Inside City Limits
or or	MD Montgo	mows:	otomac						1 ☐ Yes 2 N
Pect port	MD Montgo	mery	OLUMAC	10f. Zip Code		10	og. Citizan of WI	hat Coun	trv?
niters 23s or 28s-fs of second by notice Funeral Director	10808 Rock Run	Drive		2085			China		
by a	11. Marital Stetus 1 Never Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Yeer or Detes:		las Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispenic Origin? (Seen, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Rece Bleck Specify:	, White,	
t, the Medical	15. Decedent's l		16a. Decede	ent's Usuel Occup	pation during most of wo	rking 1	16b. Kind of Bus	iness/Ind	lustry
or other traumatic event, the Modest	Elamantary/Secondary (0-12)	Collega (1-4or 5+)	life. Di	O NOT use retire	d)	Na San San San San San San San San San Sa			
4	12	0	Hous	sewife			Home		
Be (17. Fether's Neme (First, Middle, Las	it)			18. Mother's Na	ma (First, Middle, N	faiden Sumame)	
To	Hen-Yu Cheng				Pi-Char	ng Chen			
e l	19e. Informent's Name/Raletlonship	(Type, Print)	19b. Mailing	Address (Stree	t and Number or Ri	ural Route Number,	City or Town, S	State, Zip	Code)
27 le r trau	Frank H.J. Chow-	-Son-in-Law	10808	Rock Ru	n Drive.	Potomac,	Marvla	nd 2	0854
et e	20a. Mathod of Disposition	20b. P		ition (Name of atory or other pla			20c. Location - C		
moontant: If New 27	1 X Burial 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spec	ify) Par	klawn M	Memorial	Park	2-27-99 R	ockvill	e, M	aryland
amy in	21. Signature of Funeral Service Liq	ensee L		Neme end Addre	. 11	ines-Rina			Home
	23a Fart 1. Enter the disease, on 60 shock, or heart failure. List on	lunge -			-			JI'T TI	Approximeta
Medical Examiner	disease or condition rasulting in daath) Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Ceusa (Disease or Injury that initiated events resulting in deeth) Lest	b. Arterioscle Due to (of	ras a consequ rotic h	Heart Di Heart Di Hence of):				t	1 year 15 years 10 years
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igned by the attendibe deteched for use by Physician/	Part II. Other eignificent conditions	confributing to death but not rasu	ulting in the un	derlying cause gi	ven in Pert I.	23b. Dld to	bacco use con	tributa to	the cause of death
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should should						24e. Wes er perform	n eutopsy ned?	ev-	ere eutopsy findings ellebte prior to mpletion of cause deeth?
ome 2						1 □ Ya	s XXNo	1.0	Yes 2□ No
Be Co	25. Wes case referred to medicat				00 Di				3100 2010
B B	axaminar?	Hospitet:			hor:	ath (Check only on			
unaral dire	1 Yes 2 X Yo 27. Mannar of Deeth 1 Very 1 Pending	28e. Dete of tnjury (Month, Day Year)	28b. Time of Injury	28c. Inju	→ □ Nursing i	28d. Describe ho			V)
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pletaly filled		hysician: To the best of my knowminer: On the besis of examiner and manner stated.							
To the Funeral Director: After completely filled in by the funer completely filled in by the funer Medical Certification	29b. Signeture end title of cartifier	exam.	2	29c. Licen			9d. Date signed		W = 4
)	Jour	- Lacua	_	D13	JJ7	r	ebruary	43,	エフフフ
	30. Name end eddress of person wh	completed cause of deeth (Itam	123a) (Type, P	rint)					
	Tsunie Chanchier	n, M.D., 8824 C	unningl	nam Driv	e, Berwy	n Heights	, Maryl	and	20740
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Registrar	FED 26 1	399 Beneva	Ø.	pour	2				

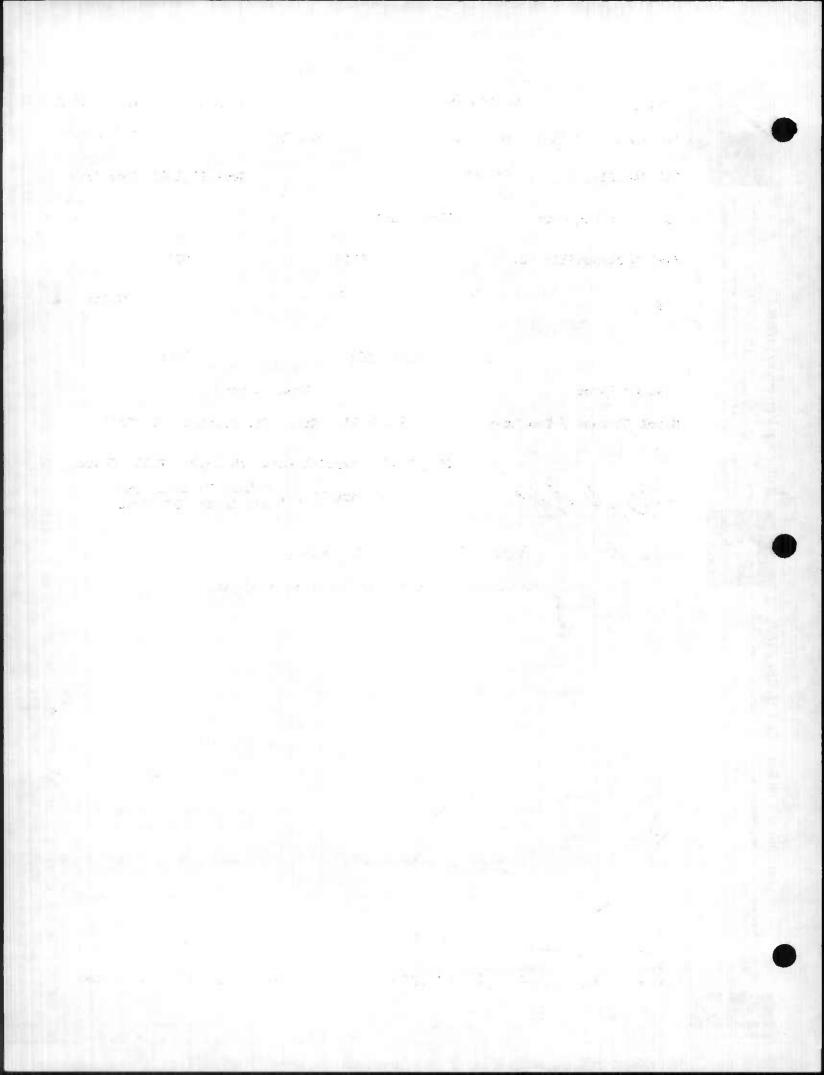
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State of Maryland / Department of Health and Mental Hygiene 9 0734

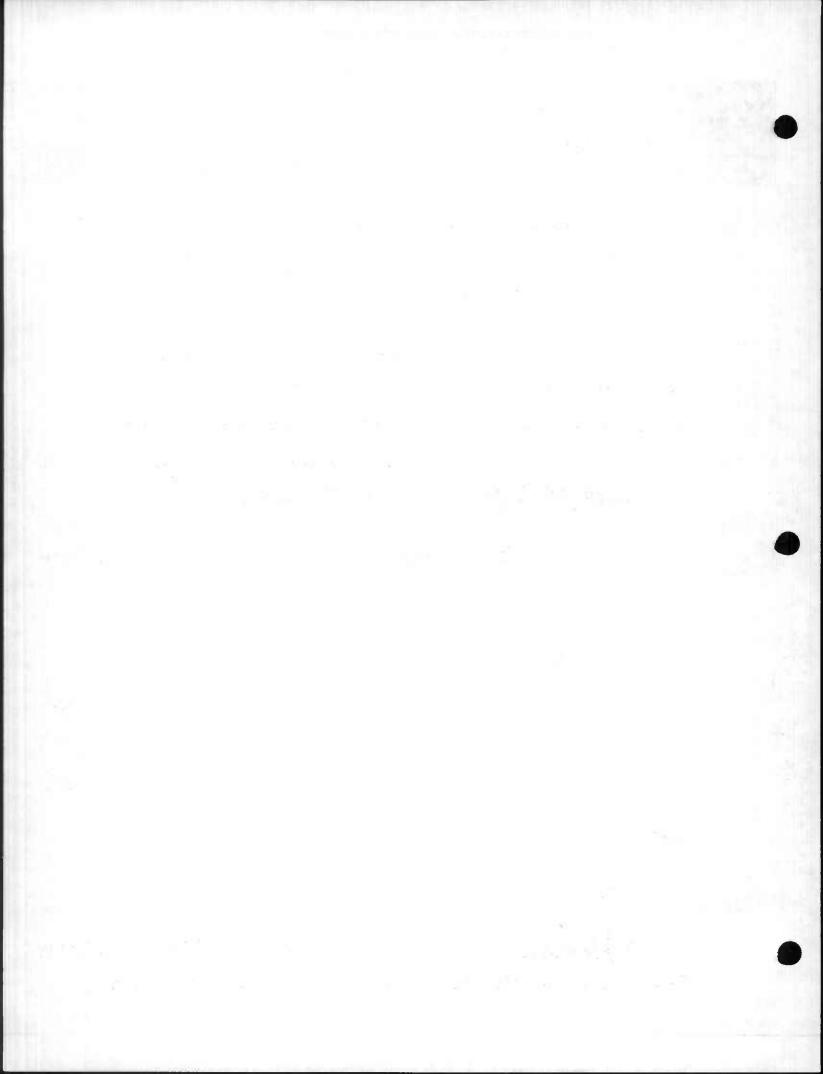
			C	ertificate of	Death		Reg. No.		
Physician /Medical	1. Decedent's Name (First, Middle, L	asi) Winkl	-EK			2. Dete of D Month		Year 1999	3. Time of Death
Examiner	4a Facility Name (If not institution, g. MOVTGOMBOLY GENE				4b. City, Town, or OUNEY	Location of Dea	th 4c. Count	y of Death	nely
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with the Maryland a or 28a-f show the notified at	Usual Residence of Decedent 10a. State 10b. County MD Montgome	rv	10c. City, Town of					10	od. Inside City Limit
or 28a-f sho	10e. Street and Number	- y	DIIVEL	10f. Zlp Code			10g. Citizen of	What Count	46
urs after death all, or hems 23 Examiner must by Funeral	2445 Lyttonsvill 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	e Rd. 12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give A Year or Dates:		20910 13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🖰 No		Specify Yes or N no Rican, etc.)		ca - America ick, White, e	etc.
	15. Decedent's E (Specify only highest g Elementery/Secondary (0-12)	ducation rede completed) College (1-4or	5+) (C	ecadent's Usual Occu Rive kind of work done fe. DO NOT use retire	pation during most of w ed)	orking	16b. Kind of E	Business/Ind	ustry
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should be nd Mental marked o umatic ev	Joseph Saron				Lena S	Saron			
ges 1 and 2 should t of Health end Mer if item 27 is marks or other traumatic	19a. Informant's Name/Relationship			Sailing Address (Stree					Code)
CENE	Carol Chernow /	Daugnter		12 Willow isposition (Name of cremetory or other ple		Date Date	20c. Location		wn, State
mit. Pages 1 er partment of Hea portant: if item: y injury or other	1X Burial 2 Cremation 3			cremetory or other pie		Feb 23	00 Fal	le Chu	urch MA
permit. Pages Department of Important: If it any injury or page.	21. Signature of Funeral Servica Lice	ensee	nang be	22. Name and Addr 254 Carro	ess of Facility	akoma Fu	neral Ho	ome	
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eath certificate be execu attanding physician and I for use as the bunal-tra cian/Medical Exar	Cause (Disease or Injury that initiated events resulting in death) Lest	c	Due to (or as a cor	sequenca of):				1	
d by the letached	Part II. Other significant conditions	contributing to death b	out not resulting in the	ne underlying cause g	iven In Part I.		d tobacco use c		the cause of deal
been shou						24a. Wa	as en autopsy formed?	cor	ore autopsy finding allable prior to appletion of cause deeth?
The lew ata has pege 2						1 🗆	Yes 2000	10	Yes 200
entific ector.	25. Was case referred to medicat examiner?	Hospital:	ent 2×ER/Outp	atient 3 DOA	ther:	eeth (Check onl)			
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he Hospital or Attending P n 24 hours aftar deeth. The Funeral Director: After to pletely filled in by the funera edical Certification:	3 Suicide 6 Could not 4 Homlcide determine	a 286. Place of in	jury - At home, farm ic. (Specify)	, street, factory, office			(Street and Num own, Stete)	nber or Rura	l Route Number,
To the Hospital or Attending Phywithin 24 hours aftar deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	(medical Exa	hyalclan: To the best miner: On the basis o and manner st	f examinetion end/o	or investigation, in my				, end due to	the cause(s)
ot with	290. Sgnature and title of certifier	_mo	(ont)	01	5736		Formo	9 27	,1999
	30. Name end address of person who	. 1 .		J Pockul	18 like	, Pocku	ille, M	0 20	0852
State Registrar	31. Date filed (Month, Day, Year) FEB 2 3 19	32. Regist	rar's Signature	9. Sport	S)				



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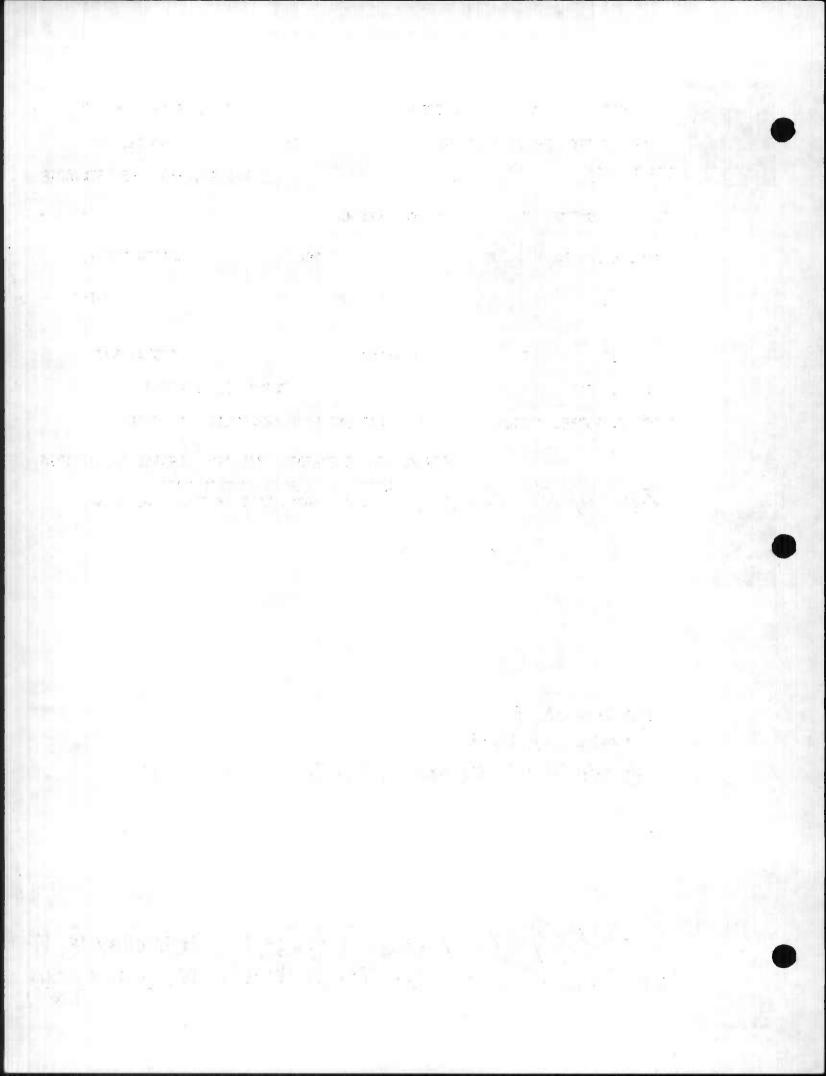
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edical	Edwa	ard R	oscoe W	iot								999		15pm
ner	4a. Facil	ity Name (/	If not institution,	give street end no	ım <i>ber)</i>				4b. City, Town, or	Location of De	ath 4c.	County of De		
	Sub	irhan	Hospit	al					Gaithersb	11170	Me	ontgom	027	
ı		Security N		6. Sex	7. Age (In yr	s. last birtl		nder 1 Year	r If Under 24 Hrs	8. Date of E			Birthplace (State Country)	or Foreign
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_	10a. Sta		10b. County		10c. (City, Town	or Location						10d. Inside C	
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100	10e. Stre	et end Nur	mber				10f	. Zip Code			10g. Citi	zen of Whet (Country?	
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by Funeral	1 🗆 1	Never Marr	led 2∰ Marrie	Armed F d 1 1 Yes If Yas, G Yeer or I	2 □ No iva 1955				ben, Mexican, Puar Specify:	rto Rican, atc.)		Black, Wi		
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	Lou	se Wi	helchel	Wint		10	Duval	7 Tan	e, Gaithe	erchura	MD	20877		
	20e. Mei	hod of Disp	position			Place of	Disposition	(Neme of		Dete			or Town, Stete	
	10	Burial 2	Cramation	3 □Removel from			y, cremetory							
	-		5 ☐ Other (Sp.		Me	trop	olitar	n Crem	natory	2/27/99	Alez	andria	a, Virgi	nia
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ian cal	sh	23a. Part1. Entar the disaase, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrast, shock, or heart feilure. List only one cause on each line.												
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-	-	er of Deatl	h 5 Pending	28e. Dete (Mon	of Injury th, Day Year)	28b. Ti	ime of	28c. Inju	ury et ork?	28d. Describ	e how Injur	y occurred		
ati	20	Accident	Investiga	ition			M		Yes 2□No					
1110		Suicide Homicide	6 ☐ Could no determin	Zoe. Place	of Injury - At	home, fer	m, streat, fe	ctory, office	•	28f. Location	(Street en	d Number or	Rural Route Nun	ber,
Certification:	"	- Torritoide		Dulla	ing, etc. (Spec	aly)				City of I	J#11, 31818			
edical C		eck only	Certifying	xaminer: On the b	esis of examir	nowledge, nation end	deeth occur Vor investiga	rred et the t	time, dete end place opinion, death occ	e, end due to It urred et the tim	ne ceuse(s) e, dete end	end manner place, and d	es steted. lue to the ceuse(3)
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			Maryland / De C	ertificate of			Reg. No.	0.7	350
Physician /Medical	1. Decedent's Neme (First, Mid	Α.	WEIDMAN		4b. City. Town, or Lo	2. Date of De Month FEBRUA	ARY 18,1		7:30 AM
Examiner Funeral Director	4a Fecility Name (# not Institute MONTGOMERY 5. Social Security Number 173 09 5455	GENERAL HO		ey) If Under 1 Year Months Days	OLNEY If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di	MONT	GOMER 9. Birthple Count	Y ece (State or Foreign ry) YLVANIA
Marylend Febow	Usuel Residence of Decedent 10a. Stete 10b. Coun MD . MONT	GOMERY	10c. City, Town or	Location R SPRING					d. inside City Limits
11215-0020 within 72 hours effer death with the Maryland ene. Then "netural", or items 23e or 28e-f show the Medical Exercities roughly and an ompleted by Funeral Director	10e. Street and Number 3850 BEL PRE	ROAD #5			1906	ecity Ves or N	10g. Citizen of V		ES
5020 cours efter de trait, or them Exercises	11. Marital Status 1 Never Married 2 Me 3 Widowed 4 Divorce	Armed Force	M(No	3. Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No No		Rican, etc.)	Specify	ck, White, e	
CA DOL .	15. Decede (Specify only high Elementery/Secondary (0-12)	ent's Education lest grade completed) College (1-4	lor 5+)	cedent's Usuel Occupive kind of work done b. DO NOT use retire	petion during most of work d)	ing	16b. Kind of Bi		ustry
yland widbe fil Mentel H Mentel H irked out atic ever	M. B. DAY 19e. Informent's Neme/Reletion		19h M	ailing Address (Stree	18. Mother's Nemi	В. 9	SEBRING		Code)
Hear Hear	NANCY E. YORK	CE, NIECE	131 20b. Pleca of Di	9 HARMONY sposition (Name of cremetory or other ple	LANE, ANNA		_	01	
Paltimore, permit. Pages 1 ar permit. Pages 1 ar Important if then any injury or other page.	1 Burial 2 Cremetion 4 Donetion 5 Other 21. Signeture of Funerel Service	(Specify)		LITAN CREM 22. Name end Addre MURIEL H.		19/99 UNERAL	ALEXAND HOME	RIA,V	IRGINIA
Physician /Medical · Examiner	23a. Pert1. Enter the disease, shock, or heart feilure/ Li Immediate Ceuse (Finel disease or condition resulting in death)		Due to (or es e con	enter the mode of dyl	5038, LAY	TONSVII	LLE, MD. errest,		2 Approximete Intervel Between Onset and Death
ords, P.O. Box 68760, requires that the death certificate be executed een signed by the ettending physician end hould be deteched for use as the buriel-transit eted by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	c	Due to (or es e con						
P.O. Box 6 hat the death certification of by the ettending period for use as Physician/Me	Pert II. Other significant condi	tiona contributing to dee	th but not resulting in th	e underlying cause gi	ven in Pert i.	23b. Did	l tobacco use co	ntribute to	the cause of death?
S, P.O. as that the degreed by the be deteched by Physic	MEUM	A100				10	Yes 20 No	3 Prob	ably 4 ☐ Unknown
	RENAL	FAILUI	. 1	0.4.	0		s en eutopsy formed?	eva	re eutopsy findings illable prior to apletion of cause leeth?
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/9	30 Name and address of perso	11/	of deeth (Item 23a) (Ty	pe, Print) P	5845°)	(I D	FEBPU DR	ARY	18, 1990
State Registrar	31. Dete filed (Month, Dey, Yea		18 gistrer's Signeture	. Spore	LE ITIL	CIT	Nr 1 DI	IVE;	20832



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State of Maryland / Department of Health and Mental Hygien 9 9 7 3 5

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Funeral Director	5	MANOR CA Social Security P 577-05-4	Number 6. 726	Sex 1□M 2∏XF	7. Age ((In yrs. last bi	rthdey) Yrs.	If Unde Months	r 1 Year			8. Date of Bi (Month, D OCT . 2)			o or Foreign
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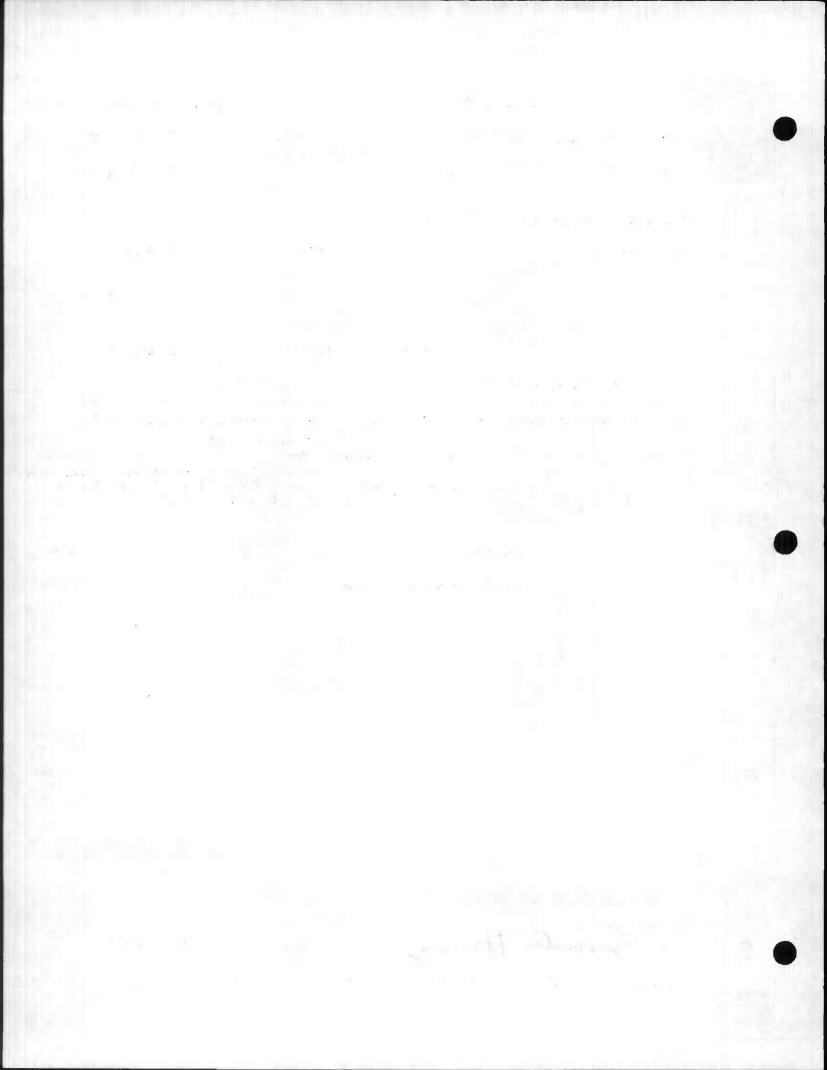
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Year February 21, 1999 **Physician** Lloyd O. Woodward 12:01 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Shady Grove Adventist Nursing Center Rockville Montgomery | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) | July 5, 1906 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□F Yrs. 227-28-0148 92 Virginia Director Usual Residence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits rel', or items 23s or 28s-f show Examiner must be notified at 1K Yes 2 No Directo Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 204 Broadwood Drive 20851 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? permit. Peges 1 end 2 should be filed within 72 hours effer of Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel; or iten any injury or other traumatic event, the Medical Exemine Black, White, etc. 1 Yes 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dry Wall Mechanic Construction 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be (Not Available) Woodward Katherine Newman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen W. Roberson/Daughter 1007 Gilbert Road, Rockville, Maryland 20851 20b. Place of Disposition (Name of cametery, crematory or other place) February 23, 1999 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland Parklawn Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Fug. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, M01126 Rockville, Maryland 20850-2805 Part I find the property or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. Untonly one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Dehydration 2 Weeks Examiner Due to (or es e consequence of): Physician/Medical Examiner Change in Mental Status 2 Weeks The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ettending physicien end for use es the buriel-fren Due to (or as e consequence of): Box 68760 Dua to (or as e consequence of) signed by the e Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco ues contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of ceuse of death? should ! Completed 24a. Was an autopsy performed' is certificete hes director, pege 2 1 Yes 2 No 1 □Yes 2 □ No Division of Vital Hospital or Attanding Physician: 24 hours after death. Be 25. Wes case referred to medical 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 27. Manner of Deatl 28b. Time of After 5 Pending Investigation 1 X Natural 1 Yes 2 No 2 Accident Director: / 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Funeral Direct mpletely filled in b 4 Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated. edical 29a, Certifier To the vithin 2 To the comple 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number D43272 February 22, 1999 30. Name and address of person who completed ceuse of death (Item 252) (Type, Print) 809 Veirs Mill Road, Rockville, Maryland 20851 Sunita Hanjura, M.D. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

State Registrar

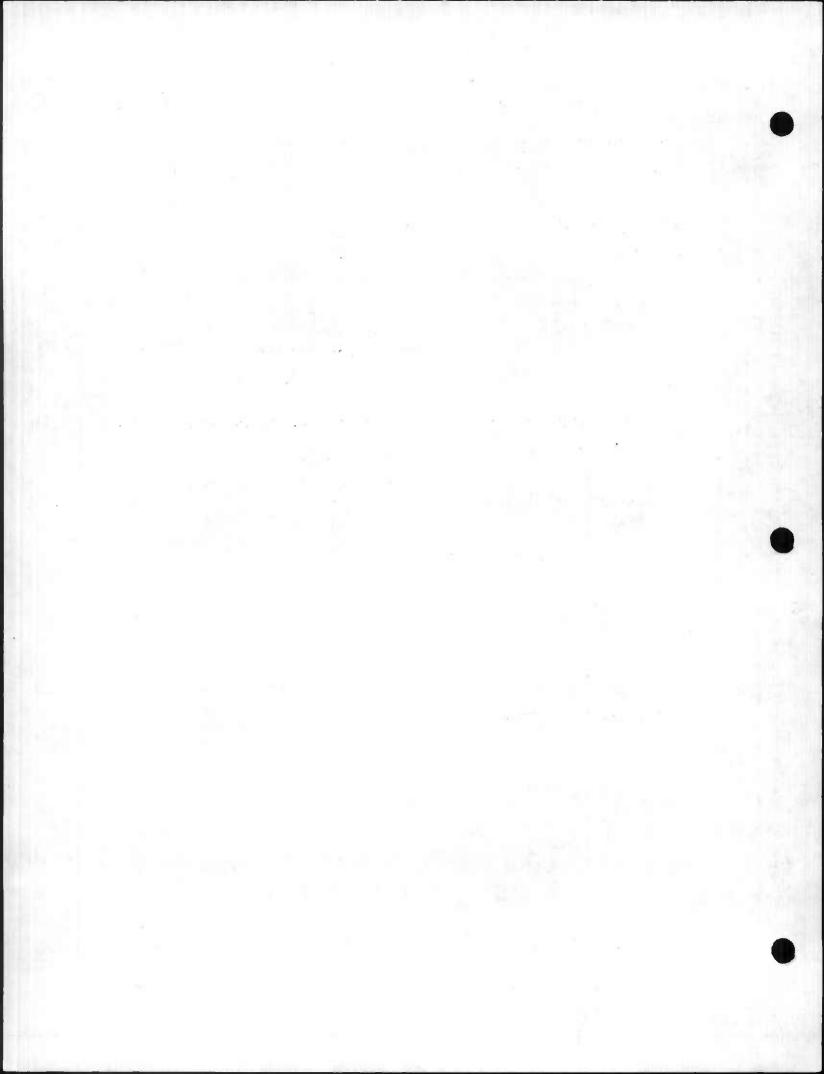
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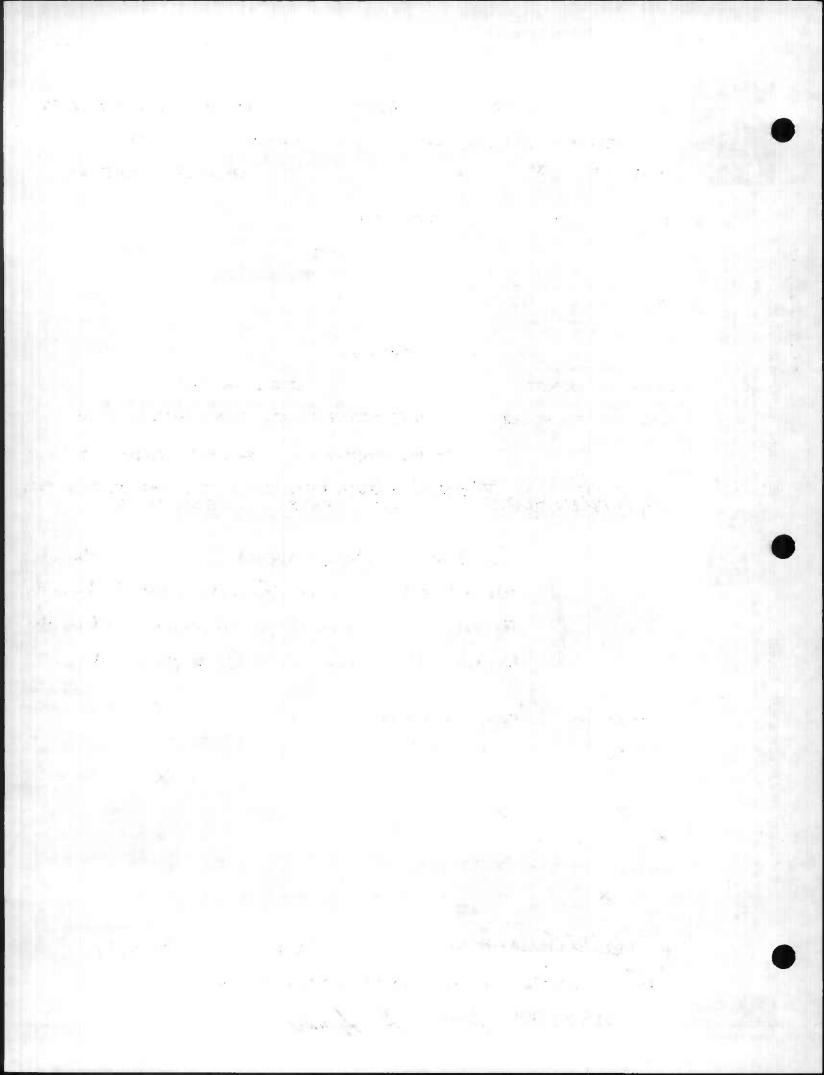
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		30. Name and address of person who	completed cause	of death (Item 23a)) (Type, Prir	nt)							
		Leon Hwang, M.D.					#606.	Kens	ington	, Maryla	ind 2	20895	
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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 20,1⁹⁹99 Month Physician February 0805 WALBERT JAMES /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, giva street end number) Examiner Talbot Easton The Memorial Hospital 8. Date of Birth (Month, Dey, Year) If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (Stete or Foreign **Funeral** Deys Hours Min. 1♥M 2□F Yrs. MARYLAND 216-18-8084 APR.14,1900 Director Usuel Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 le marked other than "naturel", or flems 23a or 28a-f ehow other traumatic event, tre Madical Examiner must be notified at the Meryle 1 Yes 2 No Director CHESTERTOWN KENT 10e. Street end Number 10f Zio Code 10g. Citizen of What Country? with USA 21620 Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - Amaricen Indian, Black, White, etc. 11 Maritel Status 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: WHITE by 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SUPERVISOR AGRICULTURE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) end Mental I JAMES Ε. WALBERT LTZZTE LARRIMORE 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) poemit. Pages 1 and 2
Depertment of Health en.
Important: If item 27 ie m
any injury or other 10269 JOHN CARVEL RD., CHESTERTOWN, MD 21620 HARRY WILLIS / NEPHEW altimore. 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 N Buriel 2 ☐ Cremation 3 ☐ Removel from State CHESTER CEMETERY 2-24-99CHESTERTOWN, MD 21620 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Nama end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Pert1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart feliura. List only one ceuse on each line. Approximete Interval Between Onset and Deeth Physician Immediete Ceuse (Finel disaese or condition resulting In deeth) /Medical Due to (or es e consequence of): arrest Examiner Examiner Corringno physician and the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Operatid region P.O. Box 68760. carinine Physician/Medical skin B temple 98 Cercinoa use Po 23b. Did tobacco use contributs to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records. þ 24b. Were autopsy findings eveileble prior to 24e. Was en eutopsy performed? Completed completion of ceuse of death? certificate hes b 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Inpatient 10 2 ER/Outpetient 3 DOA this 28a. Dete of Injury (Month, Dey Year) uneral 28d. Describe how Injury occurred 28b. Time of Injury Certification: 27. Menner of Death 28c. Injury et Work? Aftert 1 Naturel or Attending 5 Pending investigation 1 Tes 2 No 24 hours effer death. 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner es stated.

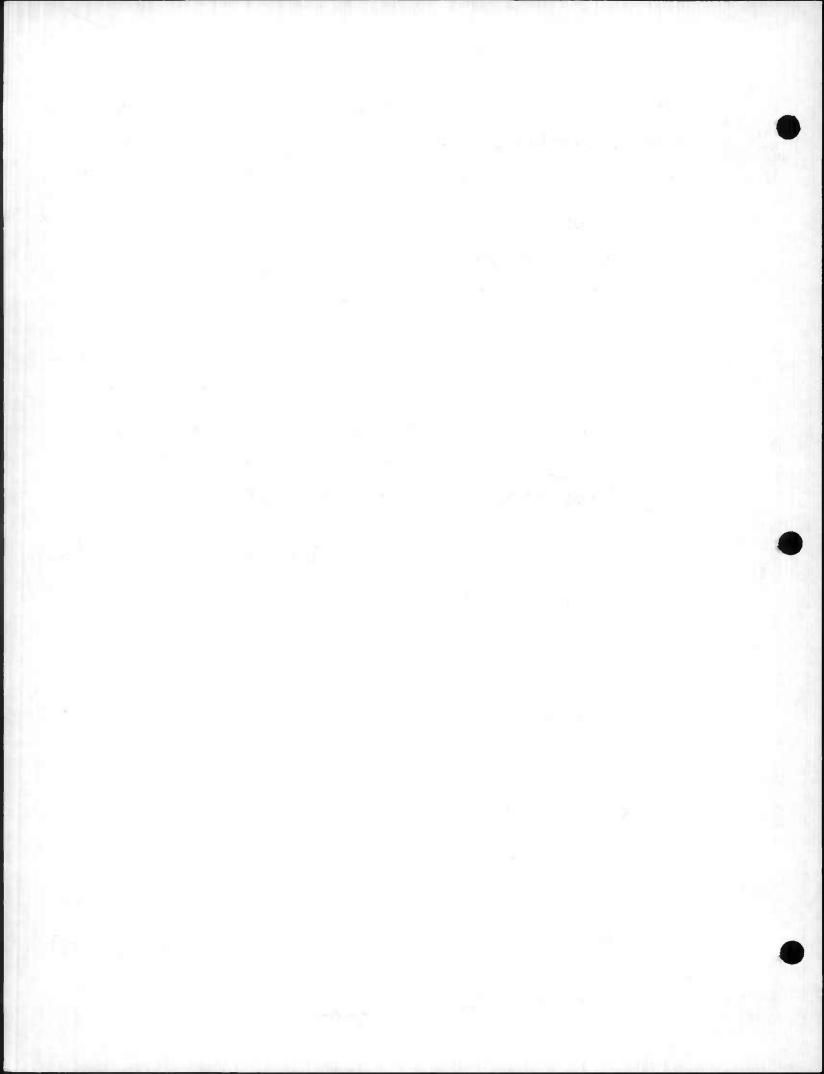
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date end place, and due to the cause(s) end manner stated. 29a. Certifier edical completely (Check only one) within 2 To the 29c. Licansa number 29d. Data signed (Month, Day, Year) D 36644 and address of person who ompleted cause of deeth (Item 23e) (Type, Print) M.D., 509 IDLEWILD AVENUE, EASTON, MD 21601 JOHN P. MASTANDREA, 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 7 3 5 5

					Certific	ate of	f Death		Reg. No.		
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s 23a or 2	Funeral Director	10e. Street end Number 29682 Skipton Co				Zip Code	25		USA		
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should be filed within 72 hours nd Mantal Hygiane. marked other than "natural", imatic event, the Medical Exa	Completed	Elementary/Secondary (0-12)	Collega (1-4or 5+)	T	oll S	uperv	/		State -	- Bay	Bridge
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hysician /Medical Examiner		shock, or heart failure. List only of Immediete Ceusa (Final disease or condition resulting in death)	e. My	600	rdia	LI	nfarct	10n			Intervel Between Onset and Death
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the eth	Physician	Part II. Other significant conditions cor	tributing to death but not i	resulting li	n the underlyi	ng cause g	jiven in Pert I.	23b. Dld	tobacco uee co	entribute to	the cause of de
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To th comp	Me	29b. Signeture end title of cartifier	,				nsa number 12359 Cne Sta		29d. Dete signe		
		30. Nema end eddress of person who co	mpleted cause of deeth (I	-	(Typa, Print)	0,000	410-	al Daile	M(-C-	414	71201
Stat	е	31. Date filed (MonFEBY2) 3 19	99 32. Regigrar's Sk	nature	uth 1	1/1	ne she	of Balt	more,	Mu.	401



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 16:24 FEBRUARY 24 1999 NANCY LEE WHITACRE 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year | If Under 24 Hrs. Birthplaca (Steta or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. lest birthdey) 8. Date of Birth (Month, Dev. Year) 1□M 20 F Months Days Hours Min Yrs. 56 216-74-4411 Feb 26, 1942 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2 No Cumberland MD Allegany 10g. Citizan of What Country? 10e. Street end Number 10f. Zip Code 1300 Kentucky Avenue USA 21502 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes ② No If Yes, Give Year or Dates: 1X Naver Married 2 ☐ Married 1 ☐ Yes 🏖 No Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Friends Aware Development Center 12 18. Mother's Nama (First, Middla, Maiden Surneme) 17. Father's Neme (First, Middle, Last) John Whitacre Susie (Fishel) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eleanor Woods--sister 1300 Kentucky Avenue; Cumberland, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Davis Memorial Cemetery 02/26 Cumberland, MD 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 21502 Cumberland, MD Approximate Interval Between Onset and Deeth 23a. Part1. Enter the disease, or combications that caused the death. Do not antar tha mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DOWNS SYNDROME 56 YEARS Due to (or es a consequence of): PNEUMONIA 1 WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2M No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

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Attending Physicien: oftar deatl To the Hospital or A within 24 hours eftar To the Funeral Director Completely filled in b.

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Physician

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Funeral

Director

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than "naturel", or items 23a or the Medical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours efter. Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturelt, or ite any injury or other traumetic event, the Mod cal Examina.

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31. Date filed (Month, Day, Year) FEB 2 6 1999

29b. Signature and title of confine



30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

29c. Licansa number

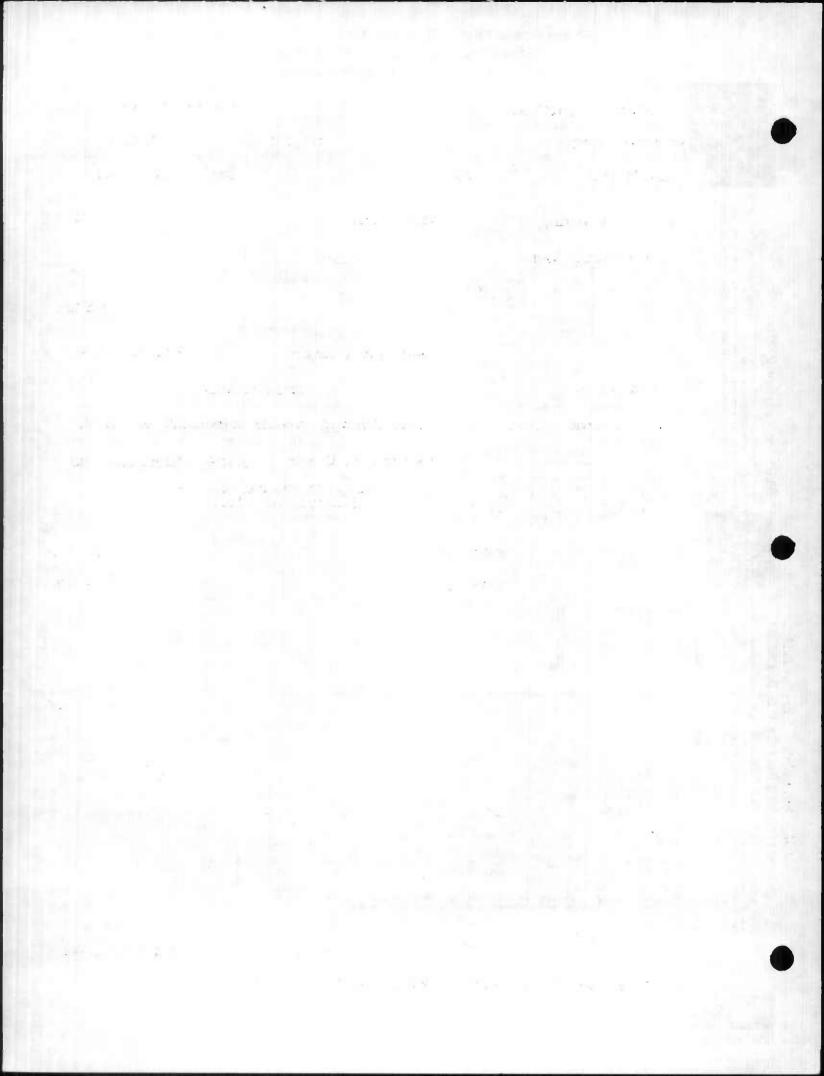
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29d. Data signed (Month, Dey, Year)

FEBRUARY 25, 1999

Registrar DHMH 16 Rev 6/95



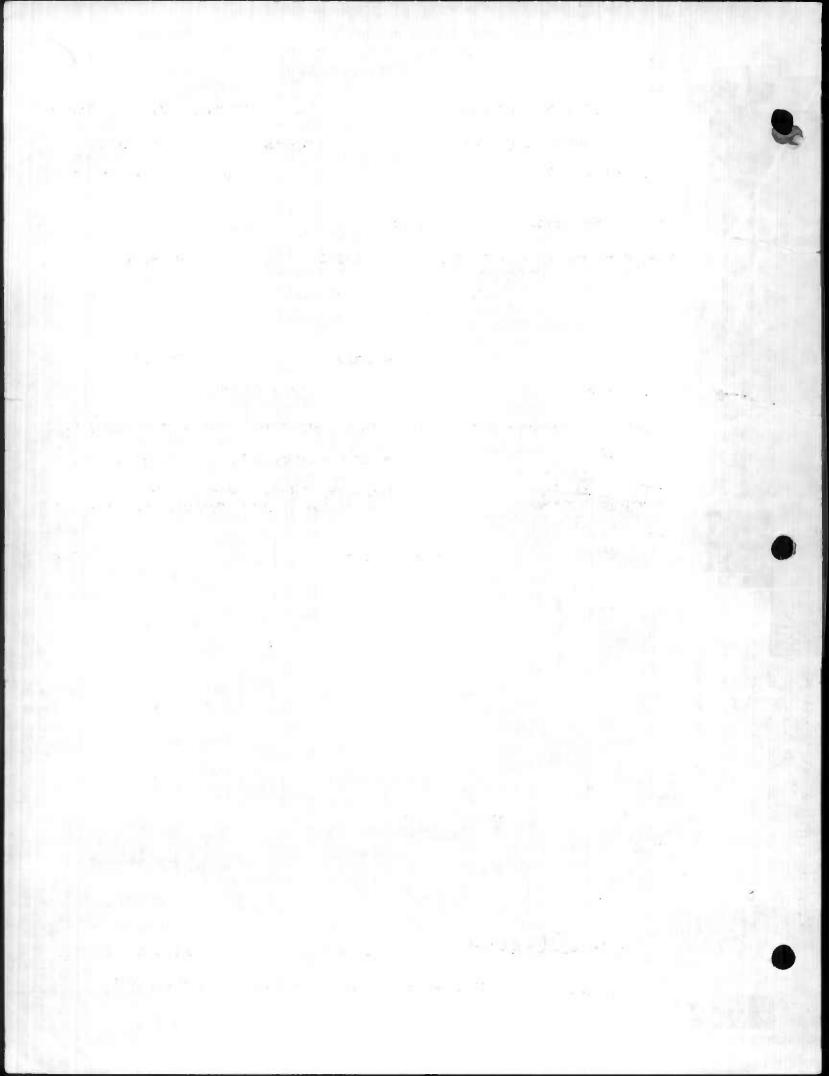
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death Month Day Year DAVID W. ZUCKERMAN February 22, 1999 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Undar 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dev. Year) ¥ØM 2□F Months Days Hours Min 95 Yrs.

1. Decedent's Nama (First, Middle, Last) 3. Tima of Death **Physician** 2:10 P.M. /Medical 4a Facility Name (If not institution, giva street and number) **Examiner** 5. Social Security Number Birthplace (State or Foreign Country) Funeral August 2, 1903 New York Director 050-10-9601 Usuai Residence of Deceden 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2√ No Director Md Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 Tuckerman Lane, Apt. 232 20852 S. Funeral A. 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes ② No If Yes, Give X. Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. 1 ☐ Never Married 200 Married 1 Yes 2 XXo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education 22 (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Years Salesman Chemicals 18. Mother's Name (First, Middla, Maiden Sumama) 17. Father's Name (First, Middle, Last) Be lental 3 Max Zuckerman Etta Krefsky 19b. Mailing Address (Street and Number or Rural Route Numbar, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 al Department of Health an Important: If them 27 is n any injury or other traus Alan J. Zuckerman - Son 1910 New Hampshire Ave., N.W., Washington, D. C. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 Buriel 2 Tremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Comfort Crematory 2/23/99 Alexandria, Virginia 21. Signature of Funaral Service Licenses 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 ntar the mode of dying, such as cardiac or respiratory arrest, Approximata 23a. Part1. Enter the disease, or complications that caused the death. Do not antar shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Deeth Physician /Medical tmmediate Cause (Final Aspiration Pneumonia 5 Days disaase or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consaquanca of): 23b. Did tobacco use contribute to the ceuse of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. XX 3 Probably 4 Unknown 0 Records. þ 2 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy Dags 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2√No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 15d Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ä funeral 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) Affair 1 Accident Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide ò To the Hospital of within 24 hours at To the Funeral D completely filled: Certifying Phyelclan: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end placa, end due to the cause(s) and manner stated. 29a. Certifier Medical 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cartifiar Duns D 33224 February 22, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Trehan M. D. 50 W. Edn 31. Deta filed (Month, Day, Year) 32. Registrar's Signature FEB 25 1999 50 W. Edmonston Drive, Rockville, Maryland 20852

State Registrar

JAKE MAD



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	Funeral Director		5. Social Security Numb 216-78-5690 Usual Residence of Dec	0 3	ex M 2□ F /.	39	last birthday Yrs.		Days		Hrs. 8. Date of (Month, Dec.			9. Birthp	olaca (State or Forei htry) MA	ign
	Marylence show	ctor	10a. State 10t	. County Harf	ord	10c. C	ty, Town or L Edgev	ocation 700d Ma	ry]	Land				1	0d. Inside City Limi 1 ☐ Yes ★★	
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Maryland 21215-0020	within and then a	Completed		-	ducetion de completed) Cotlege (1-4	or 5+)	16a. Dece (Giv. life.		done retire	eation during most of d)	f working	16b.	Kind of Br		dustry	
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Baltimore,	permit. Pages Department of Important: If Its any Injury or o		1 Burial 2 Cr 4 Donation 5 C 21. Signature of Eunera	emation 3 [y)	ate	cemetery, cre edar H	matory or oth	er pla met	ery Ma					e Marylar	nd
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Division	or Att	Certification:	4 Homicide	Could not be determined	building	, etc. (Spec	ify)	treat, factory,			City or	Town, St	ate)		al Route Number,	
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person who completed cause of death (Item 23a) (Type, Print)

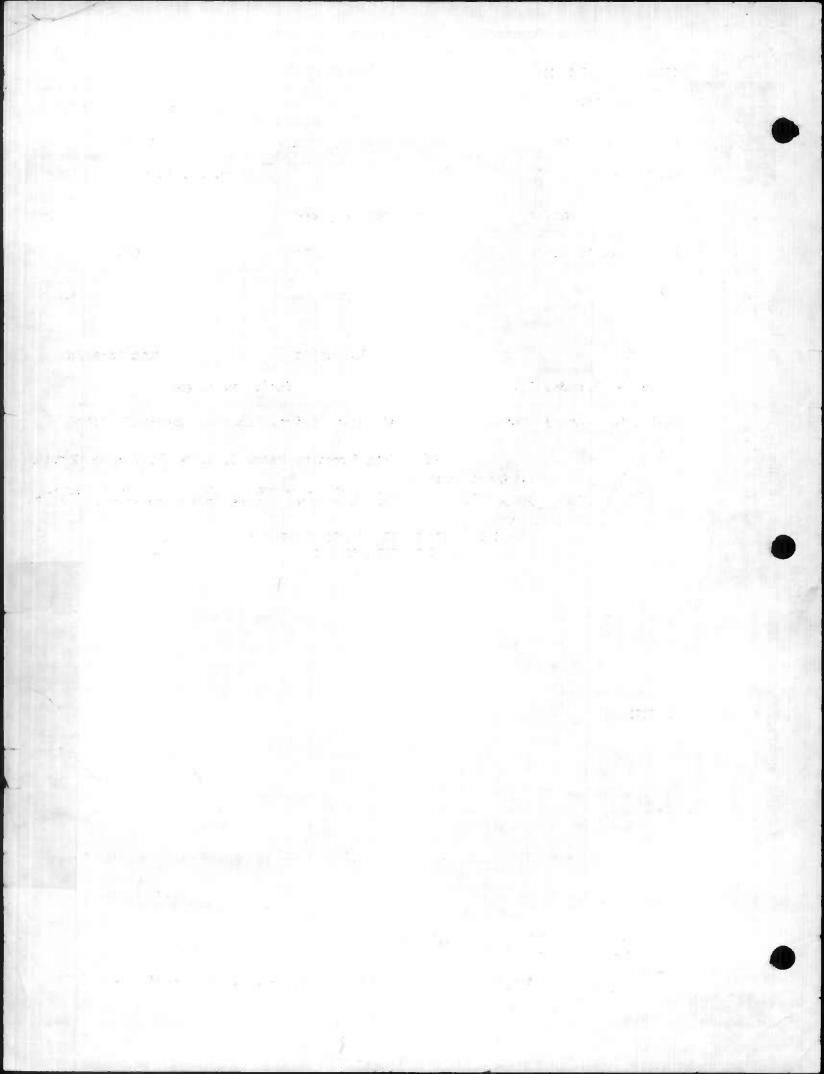
Person who completed cause of death (Item 23a) (Type, Print)

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Person who completed cause of death (Item 23a) (Type, Print)

Person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 27 Per PHY FilmG769 3-9-99 rja Certificate of Death t. Decedenf's Nama (First, Middla, Last) 2. Date of Deeth BARBER. Month Dey Yaar HARRIETTE FEBRUARY 11:30 m 23 1999 4e. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 7. Age (In yrs. last birthday) 90 Yrs. If Under t Yeer If Undar 24 Hrs. 5. Social Security Number 6. Sex 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) t□M 2XF Months 220-30-1880 MAR. 27, 1908 Usual Rasidance of Dacedant 10b. County t0c. City, Town or Location 10d. Insida City Limits t ☐ Yas 2X No BALTIMORE BALTIMORE MD 10e. Street and Numbar t0f. Zip Code 10g. Citizan of What Country? 324 CHALK HILL DRIVE 21208 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - American Indian, Black, Whita, atc. t Naver Married 2 Married 1□ Yas 2E No Specify: WHITE ₩idowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) t5. Decedant's Education (Spacify only highest grade completed) t6b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middle, Last) t8. Mothar's Nama (First, Middle, Maiden Sumama) SAMUEL ROSENSTEIN KATE LEWIS

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda)

22. Nama end Address of Facility SOL LEVINSON & BROS., INC.

TOXTORD

mP

20c. Location - City or Town, Stata

WOODLAWN, MD

RD

21236

324 CHALK HILL DRIVE - BALTIMORE, MD

HEBREW YOUNG MEN CEMETERY 2/25/99

permit. Peges 1 end 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hyglena. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show my limp or other traumatic event, "s. Medical Expirition matter be notified at Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

t0a Stata

Director

Funeral

p

Completed

Be

19a. Informent's Name/Ralationship (Type, Print)

21. Signatura of Funaral Service Licensaa

20a. Mathod of Disposition

SHEILA SMELKINSON / DAUGHTER

1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify)

Funeral

Director

Physician /Medical Examiner

nding physician end use as the buriel-trensit aftan for u been signed by tha s should be datached paga 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifics completally filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

Part1. Entar the disaasa, or con shock, or haart failura. List only	plicetions that ceused tha dea ona causa on aach lina.	ith. Do not antar tha mo	da of dying, such es cardi	ac or raspiratory arrasf,	Approximate Intarval Batween Onsat and Death
Immadiata Causa (Final disease or condition rasulting in death)	· CHRONIC	OBSTRUCT	IVE PULMO	NARY DISEAS	3
rasoning in Gaamy	Dua to	or as a consequance of):		
Sequantially list conditions, if any, leeding to immediate	b. — Dua to	or as a consequence of	;		
ceusa. Entar Undarlying Causa (Disaase or Injury thet Initiated events	C				
resulting in daath) Last	Dua to (or as a consequence of)			
	d				
Part II. Other significent conditions	contributing to death but not ra	sulting in the underlying	causa givan In Part I.	23b. Did tobacco use co	ntributa to the cause of death?
SEVERE AOR	TIC INSUF	FICIENCY.		1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
				24a. Was an autopsy performed?	24b. Wara autopsy findings evaileble prior fo complation of ceusa of death?
				t□Yas 2⊠No	1 Tas 2 No
25. Was cesa raferred to medicel axaminar?				eath (Check only one)	
t ☐ Yas 2 📉 No	Hospital: 1 Inpatient 2	☐ ER/Outpatiant 3☐ D	OA Othar: 4 Nursing	Home 5 ☐ Rasidence 6 ☐ Oth	ar (Specify)
27. Mennar of Death ★☑ Natural 5 ☐ Panding 2 ☐ Accidant Invastigatio	28a. Date of injury (Month, Day Yaar)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Dascribe how injury occur	red
3 Suicida 6 Could not b 4 Homicida dataminad		noma, farm, street, facto	ry, offica	28f. Location (Streat and Numb City or Town, State)	per or Rural Route Number,
	nysician: To the bast of my kn	owladge, daeth occurred	et tha tima, data and place	ce, and dua to the cause(s) end me	ennar es steted.
29a. Certifier (Check only one) 1 Certifying Property 2 Medical Example 1 Medical E	miner: On the basis of axamin and mannar stated.	ation and/or investigation	i, iii iiiy opinion, death occ	curred at the time, date end place,	and dua to tha ceuse(s)

20b. Place of Disposition (Nama of cematary, cramatory or other place)

State Registrar

3t. Data filad (Month, Day, Year) MAR 9 1999

AVVERAHALLI



30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

HARISH

3745

BALTMORE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day March 7, 1999 6:20 AM Irwin Augustus Berends, Jr. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 M 2□ F Days Months Hours Min 82 Yrs. Sept. 6,1916 Maryland 215-10-5860 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4107 Slater Avenue 21236 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1X Yes 2 □ No It Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Reactor Operator Soap Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irwin A. Berends. Sr. Regina Wachtler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tntormant's Name/Relationship (Type, Print) Mrs. Ruth I. Berends 4107 Slater Avenue, Baltimore, MD 21236 (wife) 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith Cem. 3/10/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home, Inc. Buconal 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. 21236 Approximate Interval Between Onset and Death METASTATIC PULLIONAPLES METATASIS Immediate Ceuse (Finai disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Due to (or as a consequence ot): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? PRECLARONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 No 1 TYes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner The law requir is that the death certificate be executed

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum page.

Physician

/Medical

Examiner

Directo

Funerai

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Completed

Funeral

Director

the Maryland

d 2 should be filed within 72 hours after death with the Manylar Ih and Mental Hygiene.
7 Is marked other than "natural", or Hems 23a or 28a-f show traumatic event, in Medical Exercise Institutional and traumatic event, in Medical Exercise Institutional and Institutional and Institutional and Institutional and Institutional and Institutional Action Institutional Action Institutional Action Institution Instituti

Baltimore, Maryland 21215-0020

Examiner physician and sthe burial-fransit Physician/Medicai attending p been signed by the should be detached þ Completed Be Certification: To

After this certificate has funeral director, page 2 or Attanding Physician: death. within 24 hours after death To the Funeral Director; / completely filled in by the f

Division of Vital Records, P.O. Box 68760,

Medicai within 2 To the

Hospital

State Registrar 25. Was case reterred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2□ Accident investigation 6 Could not be determined 28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 4 \ Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of self-lie 29c. License number 29d. Date signed (Month, Day, Year)

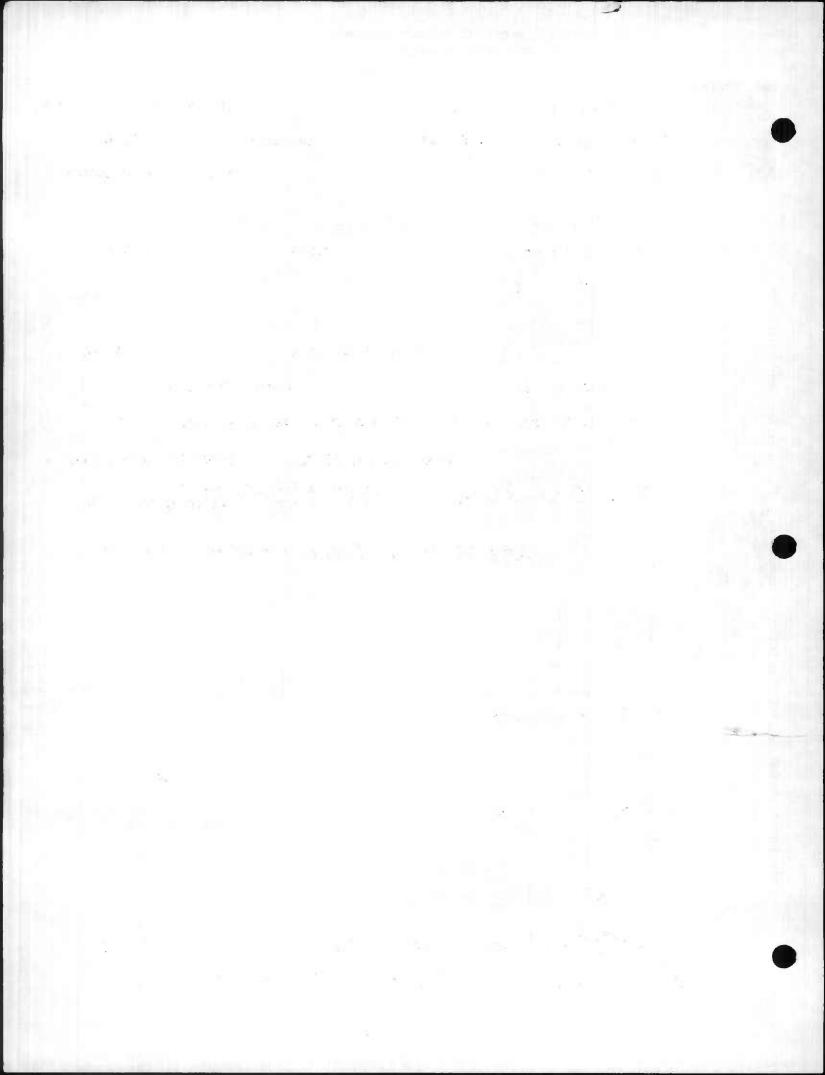
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iame and address of person who completed cause of death (Item 23e) (Type, Print)

20. BARRIONE, MAZIZZE

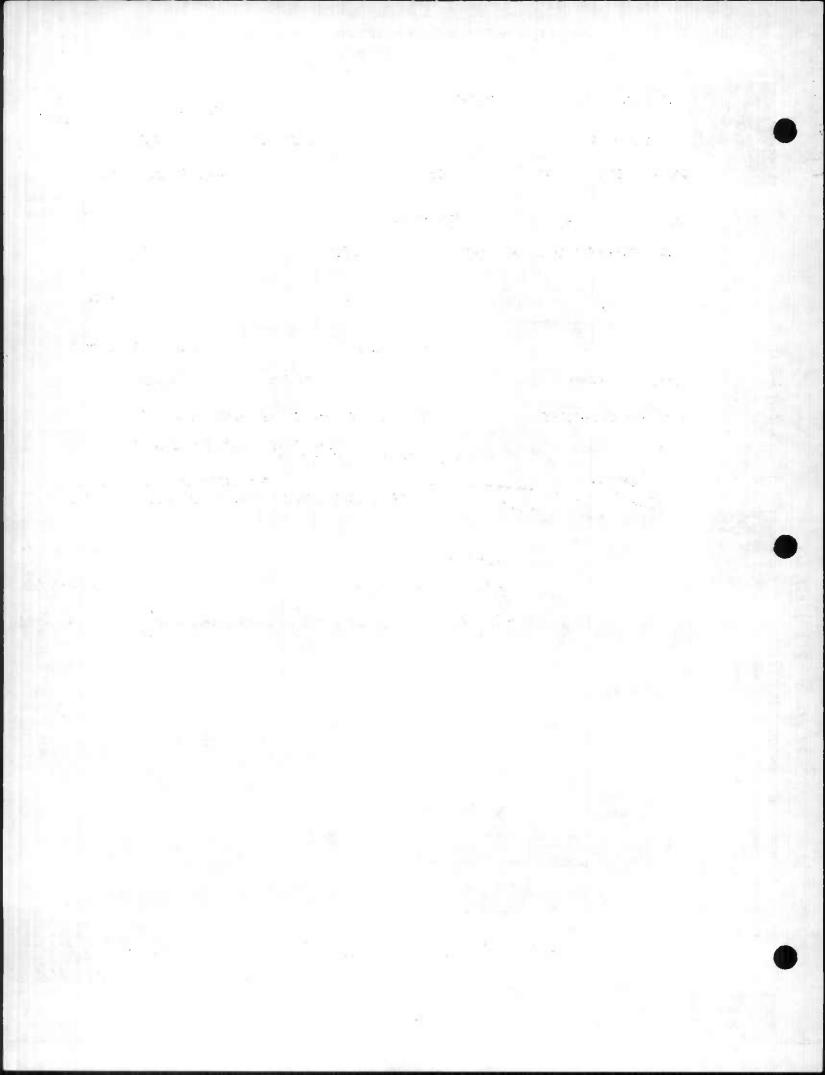
32. Registrar's Signatur 31. Dete tiled (Month, Day, Year) MAR 0 9 1999

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 0 7 3 6 |

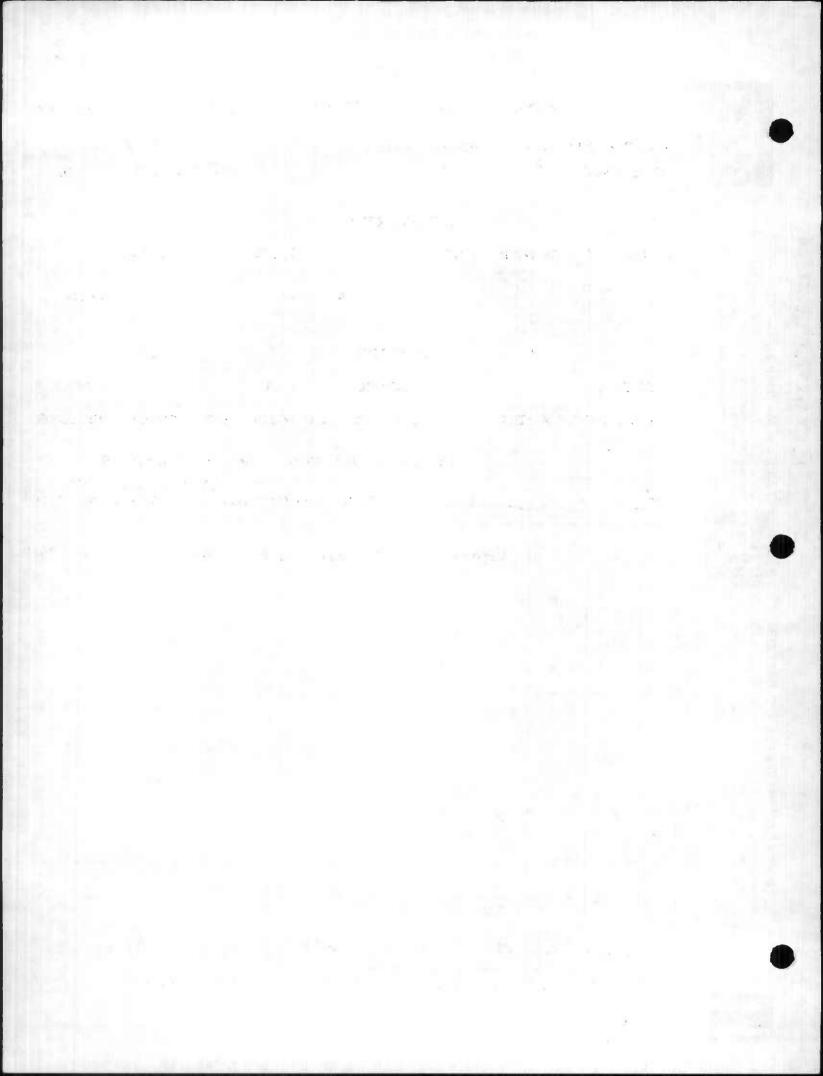
				C	ertificat	e of	Death		Reg. No.				
Physician /Medical	Decedent's Name (First, Middle MARTIN G.		2. Date of Do Month M HR	Dey	999	3. Time of Dea							
Examiner	4a Fecility Name (If not institution, LEVINDALE	4b. City, Town, or I	RE .	N/		421V							
Funeral Director	5. Social Security Number 220-03-1021 Usual Residence of Decedent	6. Sex 7. A	Age (In yrs.		Months			(Month, D	th ay, Year) 28/1936	Cou	olace (State or For ntry) XYLAND		
Maryland show	10a. State 10b. County			y, Town o	r Location						10d. Inside City Li		
th with the Maryland 23a or 28a-f show ust be notified at ral Director	10e. Street and Number 10f. Zip Code 4006 GLENGYLE AVE. APT. 1—C 21215								10g. Citizen of U.S.A		ntry?		
ter dee	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces at 1 Yes 24 If Yes, Give Year or Dates	3?] No	S.	13. Wes Decedent of Hispenic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 № No Specify:			pecify Yes or No Rican, etc.)	No- 14. Race - American Indien, Black, White, etc. Specify: WHITE				
Maryland 21215-0020 td 2 should be filed within 72 hours ef th end Mentel hygiene. 27 is marked other than "natural", or traumetic event, the Med cell Event To Be Completed by F	15. Decedent (Specify onfy highes Elementary/Secondary (§12)	's Education t grade completed) College (1-4o	r 5+)	(C		al Occu rk done se retir	ipation e during most of wor ed)	rking		6b. Kind of Business/Industry LASS INDUSTRY			
and 21 d be filed w ntel Hygier ed other th sevent, fr	17. Father's Name (First, Middle, L JOHN BYERS	(First, Middle, Last) 18. Mothe						ne (First, Middle	, Maiden Sume RUBI	me)	.1(1		
Maryla nd 2 should I ith end Men 27 is marked traumetic	19a. Informant's Name/Relationsh ALAN SALTMAN/COU						ot and Number or Ru DAD CHEVY			, State, Zij	o Code)		
Baltimore, Maryland permit. Pages 1 and 2 should be filed Depertment of Health and Mentel Hyg Important: If Item 27 Is marked othe any Injury or other traumetic event, once. To Be C	20a. Method of Disposition 1 🛱 Burial 2 🗆 Cremation 4 🗆 Donation 5 🗀 Other (Sp.	20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other CEMETERY 3/4/99BALTIMORE MD 20c. Location - City or Town, State											
Baltii permit. I Depertm Importer any Injure any Injure	21. Signature of Funeral Service 1						ress of Facility SC PERSTOWN R		ISON & B				
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/Medical Examiner	Immediate Cause (Final disease or condition resulting In deeth) e										= 1 week		
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376(ste be nysicie he bur	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of):								palh	Z ,	72 ye		
M Bull		d								<u>i</u>			
P.O nat the d by th deteche	Part II. Other significant condition	ns contributing to death	but not res	ulting In th	ne underlying o	ause g	iven in Part I.		tobacco use c Yes 2□ No	ontributa t 3 □ Pro	to the cause of de		
Division of Vital Records, P.O for Attending Physician: The law requires that the affect death. Director: After this certificate has been signed by the funeral director, page 2 should be detected in by the funeral director, page 2 should be detected in by the funeral director.								24a. Wa	s an autopsy formed?	ar Cr	Vere autopsy findir veileble prior to ompletion of cause death?		
Vital Rec									Yes 2000	1	☐ Yes 2☐ No		
Of Vita Physician: this certific ral director, TO Be (25. Wes case referred to medical examiner? 1 Yes 200 No	Hospital:	tient 2 🗆	ER/Outp	atient 3 DC	DA O	26. Place of Deather: 4 Nursing H		one) sidenca 6 □Ot	her (Speci	ify)		
Division o Bior Attending Ph s after death. al Director: After th ed in by the funeral Certification:	27. Manger of Death 1 Ornatural 5 Pending investigation 3 Suicide 6 Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 1 Work? 1 Yes 2 No							28d. Describe how injury occurred					
Tana O													
ne Hosp in 24 hou he Fune pletely fi	29a. Certifier 1 Cartifying (Check only one) Medical E	Examiner: On the basis and menner:	of examine	tion and/o	or Investigation	, in my	oplnion, deeth occu	rred et the time	, date end placa	and due	to the cause(s)		
To the trop of the	29b. Signature and title of cartifier	0	12		29	c. Lice	nse number		29d. Date sign	ed (Month	Day, Year)		
	30. Name and address of person v	who completed cause of	death (Item	n 23a) (Ty	(pe, Print)	12	elwder	aue	Rust	MA	so le		
	31. Dete filed (Month, Day, Year)	· fafa	Mu strar's Signif	21	ysyn	N.	woul		1/8 44	1000	a, a		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Month Day Yaar **Physician** HOWARD C. BERGER MARCH 4 1999 12:15PM/Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER

7 Age (lo vrs. lest birthday) If Under 1 Year TOWSON BALTIMORE If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) JAN . 11, 1 5. Sociel Security Number Birthplace (Steta or Foreign Country) 6. Sex 1 M 2 □ F 7. Age (In yrs. lest birthday) **Funeral** Months Days 74 066-18-0456 Director Usual Residence of Decedant the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 □ No Directo NY N/A NEW YORK CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or itema 23a or 32 GRAMERCY PARK SOUTH #10J 10003 U.S.A. Funeral 72 hours after death 12. Was Decedant Evar in U,S. Armed Forces? 12 Yas 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 No Specify: WHITE If Yes, Give Yaar or Dates: Specify: by 3 Widowed 4 Divorced the Medical Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ PHYSICIAN MEDICINE 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surneme) Be Pages 1 and 2 should be 1 BENJAMIN BERGER SADTE SCHTAB 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Relationship (Type, Print) EVELYN BERGER / WIFE 32 GRAMERCY PARK SOUTH #10J - NEW YORK, NY 10003 27 item 27 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 0 permit. Page Department of Important: If any injury or page. 3/5/99 HILLTOP SERVICE CORP. TOWSON, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical immediete Ceuse (Final CHRONIC MYELDID LEUKEMIA disease or condition resulting in death) Examiner Due to (or as a consequance of): Examiner physician and the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to Immediate causa. Entar Undarlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Due to (or as a consequence of): for use as Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, g The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy parformad? director, page 2 1 Yas 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical examinar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Anpatient 2 □ ER/Outpetient 3 □ DOA 2 1 Yes 2 YNo this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Avaturel 5 Pending 1 ☐ Yes 2 ☐ No investigation ector: / 2 Accident 6 Could not be determined 3 Suicida Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) Direc 4 Homlcide in 24 hour. Hospital 1x Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 29b. Signature end title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number P27730 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 COMEN, MO 6569 N. CHARIET ST STOV. MD 21204 GARY 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAR 9 **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

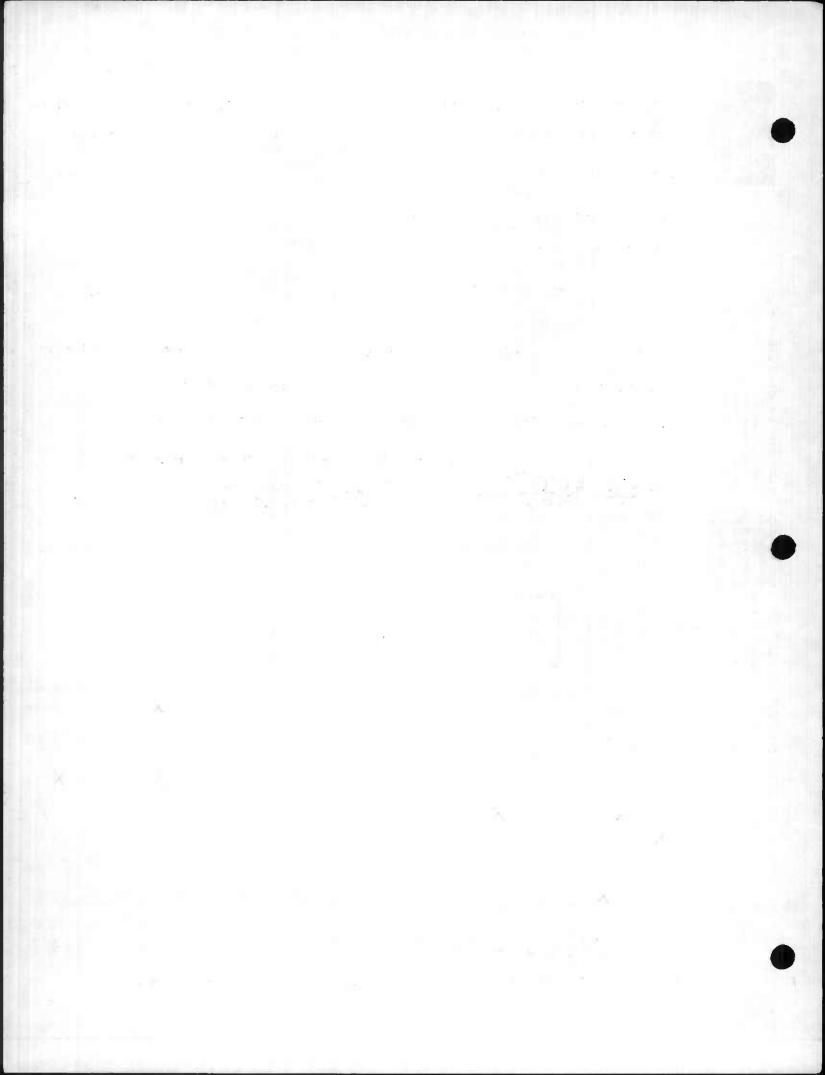
State of Maryland / Department of Health and Mental Hygiene 9 07363

	Certifica	te of Death	Reg.	No.	, , 0 0 0		
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Physician · /Medical	SELMA BI	ERMAN	Parch	3 1999	10-7		
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	cation of Death	4c. County of De	ath		
	LEVINDALE NURSING HOME	BALTIMO			N/A		
Funeral	Months	or 1 Yaar If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bi	irthplace (State or Foreig Country)		
Director	216-07-3773 85 85		SEPT.11,	1913	MD		
ž	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limit		
De notfied at Director	MD N/A BALTIMORE				15€ Yes 2□N		
Director		p Code	100	Citizen of Whet C	Country?		
23a or	3903 GLEN AVENUE	21215	1.03	U.S.A.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Funeral	11. Marifal Status 12. Was Decedant Evar in U.S. 13. Was Dece	edent of Hispanic Origin? (Spe	cify Yas or No-	14. Race - Am	nericen Indian,		
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Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mail	den Sumame)			
	SIMON H. FRIEDMAN	BESSIE		UNKN	NWC		
traumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	ss (Street and Number or Rura.	I Route Number, Co	ity or Town, State	, Zip Coda)		
- and	ROBERT BERMAN / SON 203 RIDGE	AVENUE - TOWS	SON, MD	21286			
-etho	20a. Method of Disposition 20b. Place of Disposition (Na cemetery, crematory or	me of other place)	Dafa 200	Location - City of	or Town, State		
7 9	A □ Donation 5 □ Other (Specify) Comparison State Comparison	EMETERY 3	/5/99 E	INKSBURG	G, MD		
트	21. Signature of Funeral Service Licansee 22. Name a	nd Address of Facility					
Important: If I any injury or phes.			LEVINSON				
		REISTERSTOWN R			MD 21208 Approximate		
sician	23a. Part1. Enter the disease, or complications that causad tha death. Do not antar tha moshock, or heart failure. List only one cause on each line.				Interval Between Onset end Death		
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	resulting in death) Due to (or es e consequence of						
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Examine	Sequentially list conditions, if any leading to immediate	it.					
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Physician/							
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			1 Yes	Probably 408 Unkno			
dbe	We are the second of the secon		24a. Was an a	utoney 24h	o. Were autopsy findings		
page 2 should Completed			performed		available prior to completion of cause		
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Col			1 ☐ Yes	2 No	1 □ Yes 2 No		
Be Be	25. Was cese referred to medical exeminer?	26. Place of Deeth	(Check only one)				
al din	1 Yes 2 Hospitel: 1 Inpatient 2 ER/Outpatient 3 I		me 5 Residenc		pecify)		
on:	27. Menger of Death 1 Death 1 Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 1 Injury	Work?	28d. Describe how	Injury occurred			
ed in by the funer Certification:	2 Accident investigation M	1 ☐ Yes 2 ☐ No					
d in by	28e. Place of Injury - At home, farm, streat, factor bullding, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
D O							
To the Funeral completely fills Medical C	29a. Certifier (Check only (C	det the time, date and place, e n, in my opinion, death occurre	end due to the caus ed at the time, date	e(s) and menner and place, and d	as steted. ua fo tha causa(s)		
complet	one) and mannar statad.			D	-1.5		
9 9	29b. Signature and fittle of certifier	oc. Licansa number	290.	Data signed (Mo	nun, Day, Tear)		
	Kila West have no	125/6/	1	larch	4.1999		
V	30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)	1. 1 . 1.	0 11	721	11		
/,	Debras Wertheimer No 2434 W. Be	vedere Hue	, balto	12 21	215		
State	31. Date filed (Month, Day, Year) 32, Registrar's Signature	7.					
Registrar	MAR 9 1999	arks)					

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State of Maryland / Department of Health and Mental Hygiene 9 9 0 7 3 6 4

				Certificate o	f Death		Reg. No.	07304		
	1. Decedent's Neme (First, Middle, Las	st)				2. Date of De	eath Day	3. Time of Death		
Physician /Medical	Francis Bloomf	ield Brun,	Sr.			MARI	CH 5, 1	999 1:00 PM		
Examiner	4a Facility Name (If not institution, given Saint Joseph I	street and number) Medical C	enter		4b. City, Town, o	Location of Dea	Death 4c. County of Death Baltimore			
Funeral Director	213 01 1303	D	(In yrs. last bir	Yrs. If Under 1 Yes		n. (Month, D	rth ay, Year) 18 1912	Birthplaca (State or Forei Country) Maryland		
	Usual Residence of Decedent 10a. State 10b. County		10c. City. Tow	n or Location				10d. Inside City Limi		
or 28a-f ahow a noured at	MD Baltimor		Timo					1 Yes 2 1		
r thems 23a or 28a-f aho	10e. Street and Number 213 Sandee Roa	d	21093		10g. Citizen of N	What Country?				
by by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Co		Specify Yes or N into Rican, etc.)	o- 14. Rac Blac Specify	a - American Indian, ck, White, etc. :: White		
ygiene varieties, voi pour yann naturel, in the Medical Ex.	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucetion de completed) College (1-4or 5+)	Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret	upatic le during most of w red)	orking		usiness/Industry		
Hygiene. ther than and, the Me	12	n/a	N	Manager				Manufacturing		
d oth	17. Father's Name (First, Middle, Last)					ame (First, Middle		10)		
Ments Ments To T	Edward Brun					Bloomfie				
other traumatic event, the let	19a. Informant's Name/Relationship (Mailing Address (Stre 3 Sandee			ber, City or Town, Stete, Zip Code) MD 21093			
or othe	20a. Method of Disposition 1 → Burial 2 □ Cremetion 3 □			Disposition (Name of ry, crematory or other p		Date				
rtmer rtant:	4 Donation 5 Other (Specify		Loudo	n Park Ce		3/9/99 Baltimore, MD				
populiti. Fages Department of the Important: If its any Injury or of ones.	21. Signature of Fundamental Supplemental Michael . Fla		_		Funeral adonia Re		anium A	AD 21093		
	Michae . 13 23a. rm. Enter the diseese, or com- shock, or heart failure. List <i>on</i> ly	olications that coused t	he death. Do	not enter the mode of	ying, such as cardi	ac or respiratory	arrest,	Approximate		
Physician	snock, or neart failure. List only	one cause on each line).					Interval Between Onset and Death		
/Medical	Immediate Cause (Final disease or condition	UROSEPS	IS					4 DAYS		
xaminer	resulting in death)	a	oue to (or as a	consequence of):						
oir sit		b								
ng physician and as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c		consequence of):						
2 2 3		d								
he att	Part II. Other significant conditions of	ontributing to death but	not resulting I	n the underlying cause	given in Pert f.	23b. Dfc	tobacco uee co	ntribute to the cause of des		
igned by the attendir be detached for usa by Physician/A	Marine V					10	1 ☐ Yee 2 No 3 ☐ Probably			
cata has been signed by the attending page 2 should be detached for use Completed by Physician/I	1,:4-11			4			s an autopsy formed?	24b. Were autopsy finding available prior to completion of cause of death?		
oage						1	Yes 2 No	1 □ Yes 2 No		
certificata rector, pag	25. Was cese referred to medical examiner?				26. Place of D	eath (Check only	one)			
After this funeral di	1 Yes 2 No 27. Menner of Deeth 1 Natural 5 Pending 2 Accident Investigation	Hospital: Inpatien 28e. Date of Injury (Month, Dey		Time of 28c. Ir		Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 2 No				
within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Sulcide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	rm, street, factory, office	ce	28f. Location City or To	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)			
Et hours Funera letaly fille			examination an	e, death occurred et the d/or investigation, in m				anner es stated. and due to the cause(s)		
within To the	29b. Signature and title of certifier				ense number		29d. Date signe	ed (Month, Day, Year)		
	> natividad	D. de Le	on, m	.D. D195	08		march	-5,1999		
	30. Name and address of person who				HE TON	CCN MI	N			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** DOROTHY BRANDFORD 1999 6:55a march /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street end number) 4c. County of Death **Examiner** BALTIMORE MERCY HOSPICE 8. Data of Birth Month, Day, Year) 10/15/38 If Undar 1 Year If Undar 24 Hrs. 9. Birthplace (State or Foreign Country) VIRGINIA 5. Social Sacurity Number 7. Age (In yrs. lest birthday) Months Days Hours Min 1□M 2#F 60 Yrs. 215 38 7717 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ₩ Yes 2 No Directo MD. N/A BALTIMORE 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number USA 915 N. BENTALOU ST. 21216 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritai Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: AFRO AMERICAN 1□ Yes 2 HNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Elamentary/Secondary (0-12) College (1-4or 5+) SCHOOL SYSTEM CAFETERIA COOK 12 18. Mother's Name (First, Middla, Maiden Sumama) 17. Father's Name (First, Middle, Last) Be HENRY SCOTT ROSE M. REVEL 2 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) CHARLES BRANDFORD HUSBAND 915 N. BENTALOU ST. BALTO. MD. 21216 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 # Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEM. PARK 3/8/99 WOODLAWN, MD. BALTO. CO 22. Name and Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21. Signature of Funeral Service Licensee 23a. Pert1. Ether the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on much line. Approximate Intarval Batween Onset end Deeth Immediate Cause (Finel disease or condition resulting In death) Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Wunknown à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? 2 000 1 ☐ Yas 2 ☐ No 1 Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) STEILA MARIS AT MERCY Other: 4 Nursing Home 5 Residence 6 Other (Specify) # 05 D *C 1 Yes 28 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of Certification: 1 Watural 5 Pending 1 Yas 2 No investigation 2 Accident 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and manner es stated. Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only one) 29c. License number 29d. Dete signad (Month, Dey, Yeer) 29b. Signature and title of cartifier Stal (hu 3 49 D40854

Registrar

Funeral

Director

item 27 is marked other than "natural", or itema 23a or other traumatic event, the Medical Examiner must be a

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/Medical Examiner

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Division of Vital Records, P.O. Box 68760,

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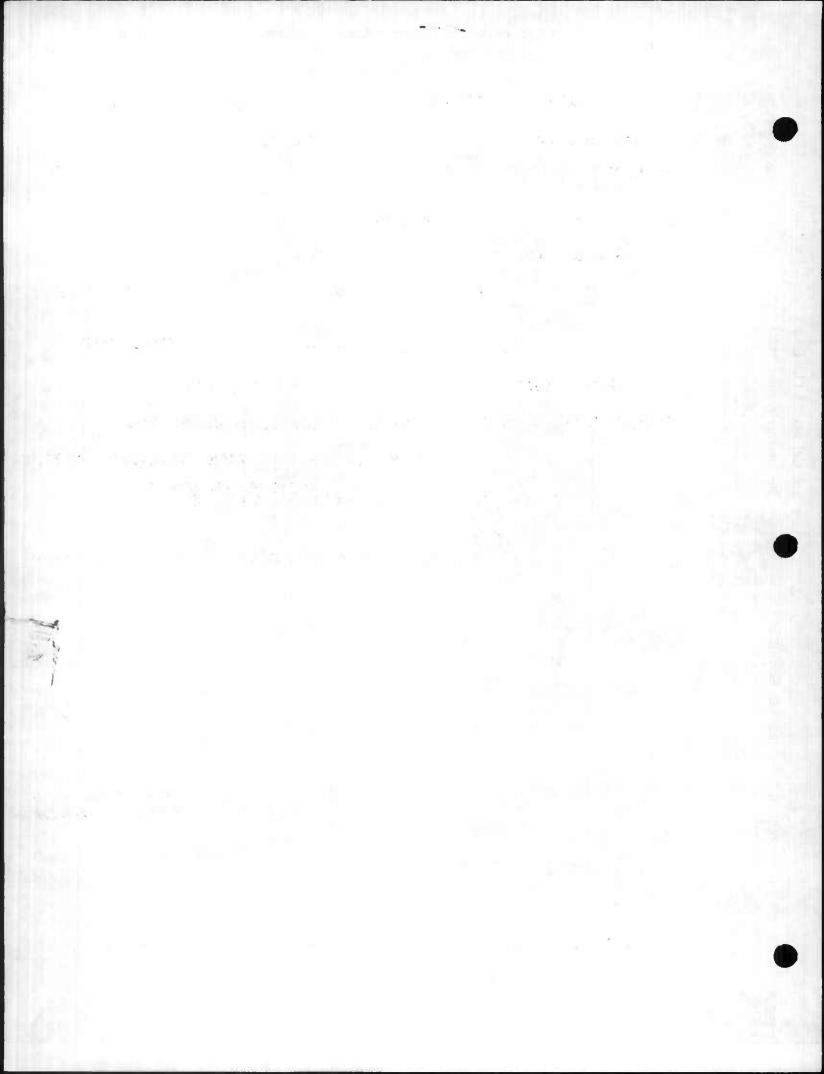
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Dand Rushes, MD 301 St Park P 32. Registrar's Signature

> MAR 9 1999

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** 06, 1999 JOHN HENRY BRIGHT 1:15 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Howard County General Hospital Columbia Howard If Undar 1 Year | If Under 24 Hrs. Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1⊠M 2□F Days Hours Min Yrs 578-20-7675 72 1926 Nov 25, Director North Carolina Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d, fnsida City Llmits 1 ☐ Yes 2 No Directo Anne Arundel Laurel 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 8283 Brock Bridge Road 20724 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Giva Yaar or Datas: Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Bace - Amarlcan Indian. 11. Marital Status Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours efter Department of Haatth and Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or item any injury or other treumatic event, the Medical Exempton 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Grade 8 Carpenter Construction 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) James Wilson Bright, Sr. Dezie Lee Davenport 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Barbara A. Lawson/daughter 2044 Horseshoe Circle, Jessup, Maryland 20794 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □ Donation 5 □ Othar (Spacify) Fort Lincoln Cemetery 3/9/99 Brentwood, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funaral Sarvica Licensee 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the dispase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fallers. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting In daath) /Medical 2 weeks Aspiration preumonia Examiner Examiner ere brovas cular months Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) labetes Physician/Medical Due to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the causa of death? Carcinomy 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of daath? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28d. Dascribe how Injury occurred 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: 5 Panding Invastigation 1 Naturai 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba datarmined 3 ☐ Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 T Homicida 29a. Certifian 1/15 Certifying Physician: To tha bast of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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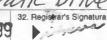
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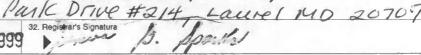
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30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) Lynne Gaynas MO

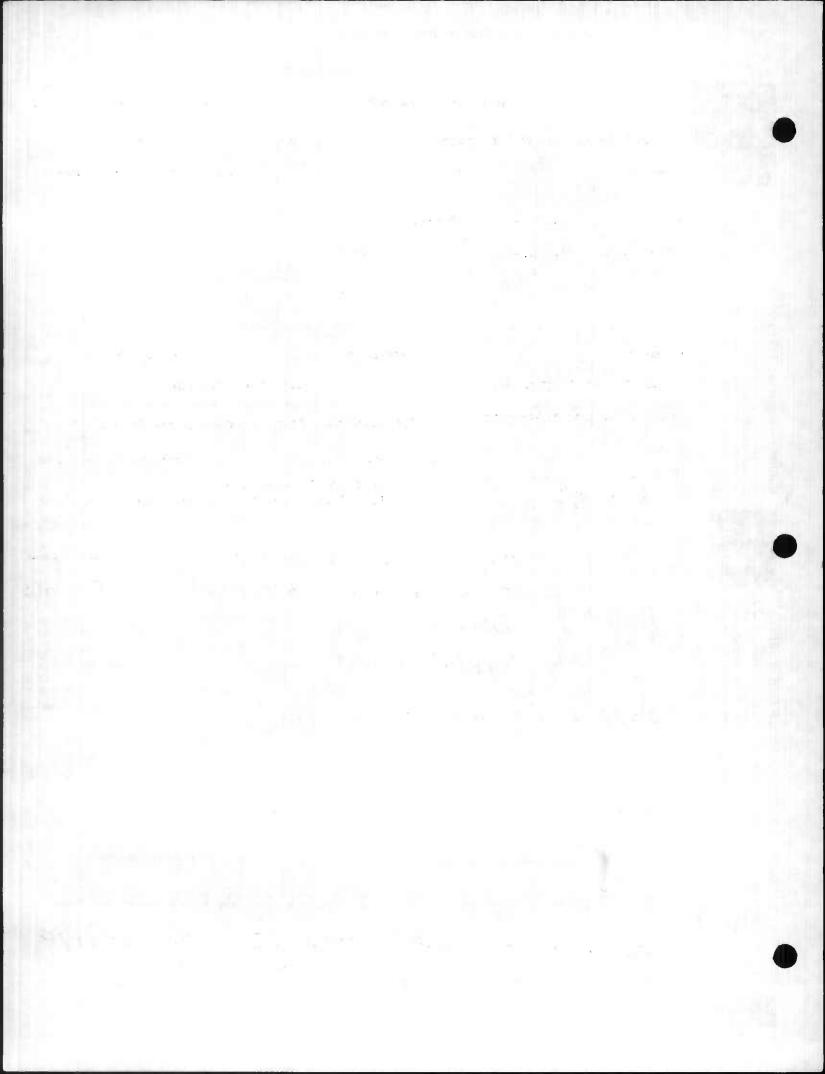


29c. Licansa number

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29d. Date signed (Month, Day, Yaar)

March 8, 199



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 5, Howard E. Brunner 12:04 p.m. 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Carroll County General Hospital Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex. 1 2 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 216-03-3704 Director May 9, 1914 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner numb be motified at Md. Baltimore Reisterstown Director 1 ☐ Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 229 Candytuft Rd. 21136 U.S.A. death Funeral 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status 1 Yes 2 No If Yes, Give Yaar or Datas: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry I Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Police Officer Baltimore City Police permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygie Important: if item 27 Is marked other 1 any Injury or other traumatic event, In 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Claude Brunner Catherine Poulson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Therada Brunner - wife 229 Candytuft Rd. Reisterstown, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State 120 Burial 2 Cremation 3 Removal from State LakeView Mem. Park March 8, 1999 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Md. 22. Name and Address of Facility 21. Signature of Euneral Service Licenses Guth Eckhardt Funeral Chapel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate shock, or haart failura. List only one cause on each line. Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final aidiae disease or condition resulting in death) Examiner Myocendial Infarction Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last Athero scenotic Coronay Vascular dist P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Diabetes Mellitus 15 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown renal disease 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No certificate director. Be 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | DER/Outpatient 3 | DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of After 1 DNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide

Records, Division of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: Af To the P within 2 To the F

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29a. Cartifier (Check only one)

29b. Signaturerend title of certifier

1999

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

1838 Greene Tree Rd Suite 245 Baltimore mo 21208 Jokel Lahn mp

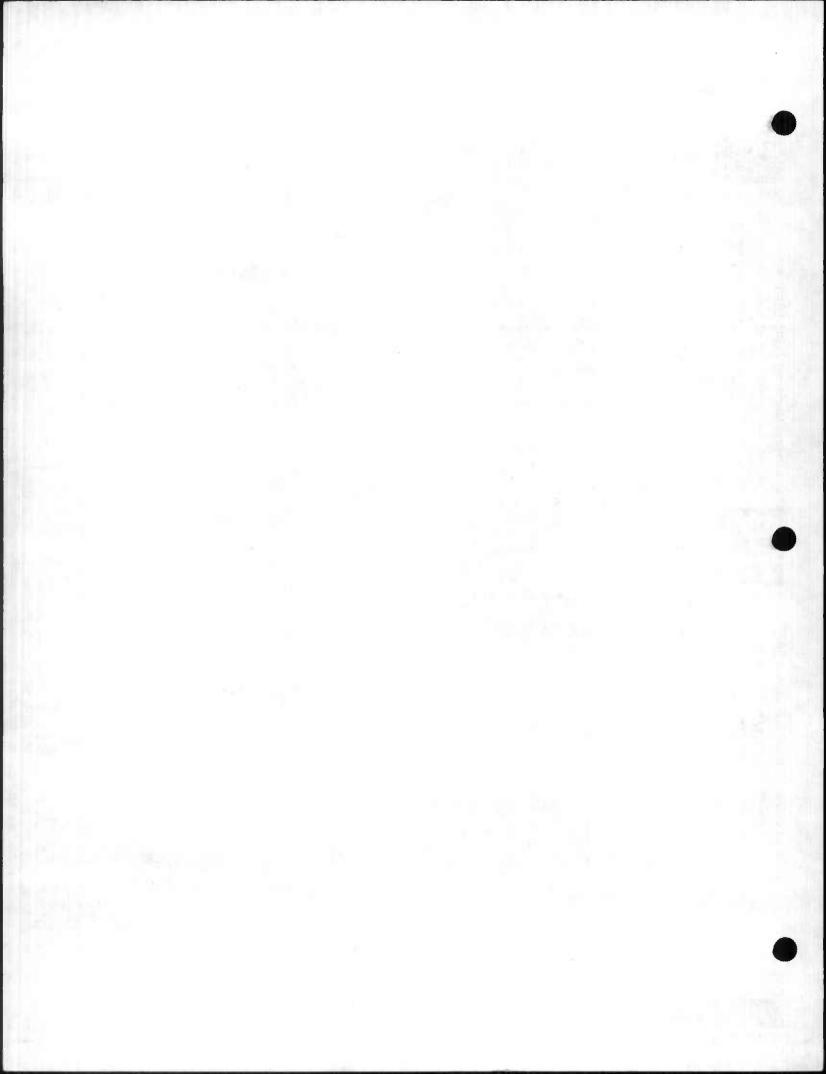
1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

State Registrar 32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1999 John T. Burns Mar. 3 11:15 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** 5400 Vantage Point Road Apt. 715 Columbia Howard If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 M 2 □ F Yrs 215-38-3533 90 Sept. 5, Director 1908 Missouri Usual Residence of Decedent Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23s or 28s-f show traumatic event, he Medical Examinar must be notified at Howard Columbia 1 ☐ Yes 2 ☑ No Director 10e. Streat and Number 10f. Zip Code 10a. Citizen of What Country? 5400 Vantage Point Road 21044 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after. Department of Heelth and Mental Hygiene. Important: If Itam 27 ia marked other than "natural", or ite, any injury or other traumatic event, the Medical Experiment 1 ☐ Never Married 2 ☑ Merried 1 Yes 2 No If Yes, Give Year or Detes: altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Attorney 5+ Lawyer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Alpha L. Burns Ann F. (McGowan) 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kathleen H. Burns (Wife) 5400 Vantage Point Rd. Columbia, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place)
Gate of Heaven Cem. 20a. Method of Disposition MarPete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 10, 1999 Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. Lemmer 5555 Twin Knolls Rd. Columbia, MD 21045 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Anylower /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Lest the burial-tran Due to (or as a consequence of) The law requires that the death certificate be exec Box 68760. silum Physician/Medical Due to (or as a consequence of) USB 88 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably Unknown þ Records, should be Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1□ Yes 2000 certificate 1 ☐ Yes 2 ☐ No of Vital Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 25 No edical Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Affer Division 5 Pending Investigation 1 Detural death. 2 Accident after death filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital c within 24 hours a' To the Funeral D completely filled 1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signattyre and title of confifier 29c. License number 29d. Date signed (Month, Day, Year) Muhnett. 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 0 Colubios, Mus 11055 State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Verta 1999 march 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Medica Balto .iberty n If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthpiaca (Stete or Foreign Country) 1□M 2 F Deys Min. Months Hours Yrs. 73 216-20-5579 Aug. 6,1925 Va Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD n/a Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4413 Springdale Avenue 21207 USA 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Raca - American Indien, Bieck, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes Black. 16e. Decedent's Usuel Occupetlon (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) 12 Beautician Cosmetology 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Albert Underwood Virginia Lewis 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Bartley/husband 4413 Springdale Ave. Balto., MD 21207 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete to Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3/10 Garrison Forest V.A. Owings Mills, 21 Signature of Funerel Service Licensee 22. Name end Address of Fecility James A. Morton & Sons F.H., Inc 1701 Laurens St. Balto., MD 21217 Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, note, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth Probable acerde M Immediete Cause (Finei disease or condition resulting in deeth) 1, ens Due to (or es e consequenca of): 23b. Did tobacco use contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

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The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760,

Physician

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Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

2 No 1 Yes

1 □ Ves 2 □ No

25. Wes case referred to medical examiner? 26. Pleca of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 € DOA 28b. Time of

27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 1 Neturel 5 Pending 2 Accident investigetion

6 Could not be determined

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Certifying Phyercian: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) end menner stated.

(Check only one) 29b. Signeture and title of certifier

3 Sulcide

29e. Certifier

4 Homicide

29c. License number

29d. Dete signed (Month, Day, Year) CI

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) R. JAT. 2360 CLAMISEN Blud

State Registrar

31. Dete filed (Month, Dey, Year)

MAR 9 1999 32. Registrer's Signeture

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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dala of Death 3. Time of Death Livingston Nicholas Banks Month 2010 March 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Arundel Medical Center Anne Arundel Annapolis H Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Months Days 180M 2□ F March 2, Usual Residence of Decedant 10a Stala 10b. County 10d. Inside City Limits 10c. City, Town or Location Queenstown 1 Yes 2 No Anne's Md Queen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 200 Belle 21658 Point Drive U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, atc. Interacial 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: (Black + White) 3 Widowed 4 Divorced Year or Dales 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry NH Elamantary/Secondary (0-12) College (1-4or 5+) MA 18. Mother's Neme (First, Middle, Maiden Surnama) 17. Falher's Name (First, Middla, Last) Wallace Banks Christine Virginia Leonrad Livingston 19a. tntormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Belle Point Dr. Queenstown, Md. 21658 Livingston Banks father 20b. Place of Disposition (Nama of comatery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stele 1 ☐ Burial 2 Cremetion 3 ☐ Removal trom State 4 ☐ Donation 5 ☐ Other (Specify) 03/09 Baltimore, MD 21 Signature of Funeral Service Licen-22. Neme and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Entar tha diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate causa. Enler Undarlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 100 3 Probably 4 Unknown ventricular infactor 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy parformed? encephalopath 1 ☐ Yes 2 000 1 Yes 2 No 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

and for use as the buria Box 68760. P.O. Division of Vital Records,

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, I

Physician /Medical

Examiner

Physician

/Medical

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Baltimore, Maryland 21215-0020

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29a. Certifier (Check only one)

3 ☐ Suicide

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Decrifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end dua to tha cause(s) and mannar as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stelled.

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Nema and address of person who completed causa of death (Item 23a) (Type, Print)

las 00

28e. Place of tnjury - Al homa, farm, street, factory, office building, etc. (Specify)

Rindfleisch DO 2001 Medical Pkwy Annapolis, Md. 2140/

Suzanne 31. Dale filed (Month, Day, Year)

32. Registrar's Signatura

MAR 9

Registrar **DHMH 16 Rev 6/95**

State

Physician /Medical Examiner The law requires that the death certificate be executed physician end s the burial-transit

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s certificate hes b director, page 2 s

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to

Physician

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Director

r than "naturel", or itema 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after mart of Health and Mentel Hygiene. In and 17 is marked other than "naturel; or file ury or other treumatic event, the Marine Evantor.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. CHRONIC OBSTRUCTIVE LUNG DISEASE

DEHYDRATION

25. Was case referred to medical

1 Yes 2₽ No 27. Manner of Death

> 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29b. Signeture end title of certifier

29e. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner es ateted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end menner stated. 29c. Licensa number 29d. Data signed (Month, Day, Year)

RESIDENT HOUSE STAFF

March, 8

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ATHIR MEROGI

1. 31. Date filed (Month, Dey, Year)

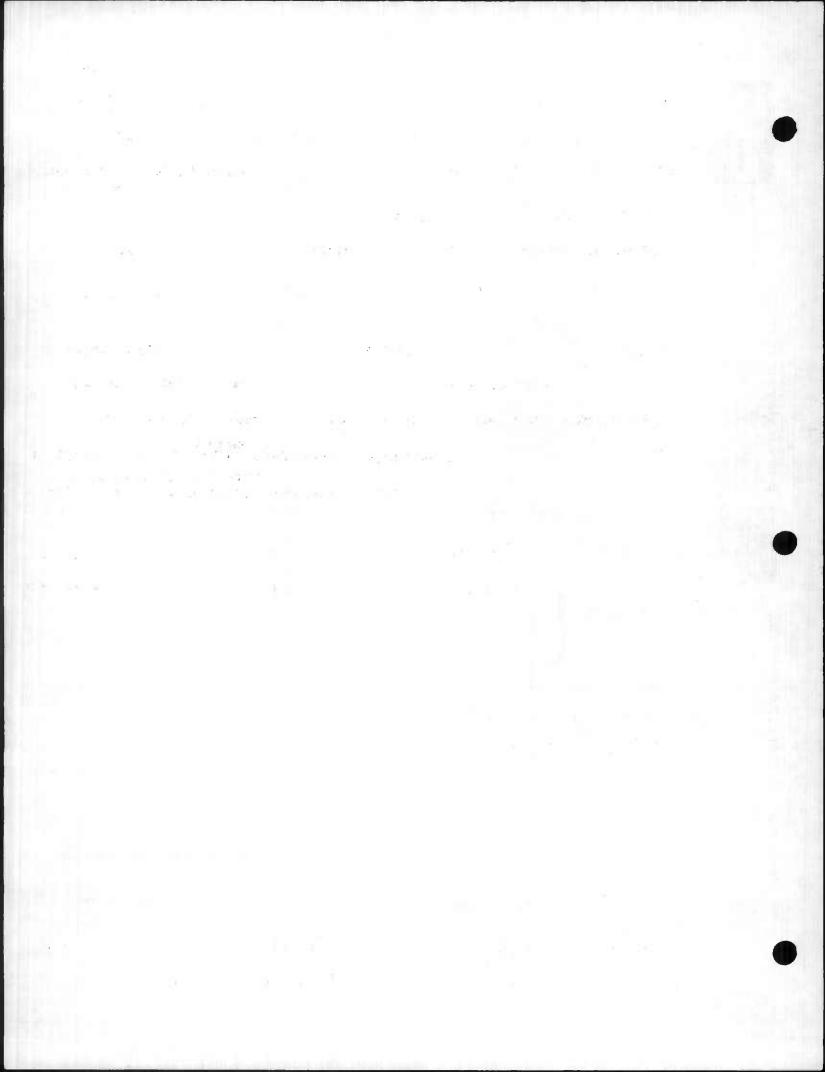
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State Registrar



filed within 72 hours after death with the Maryland

Pages 1 and 2 should be filed within 72 hours nent of Haalth and Mantal Hygiene. ant: If Item 27 Is marked other than "natural",

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, I

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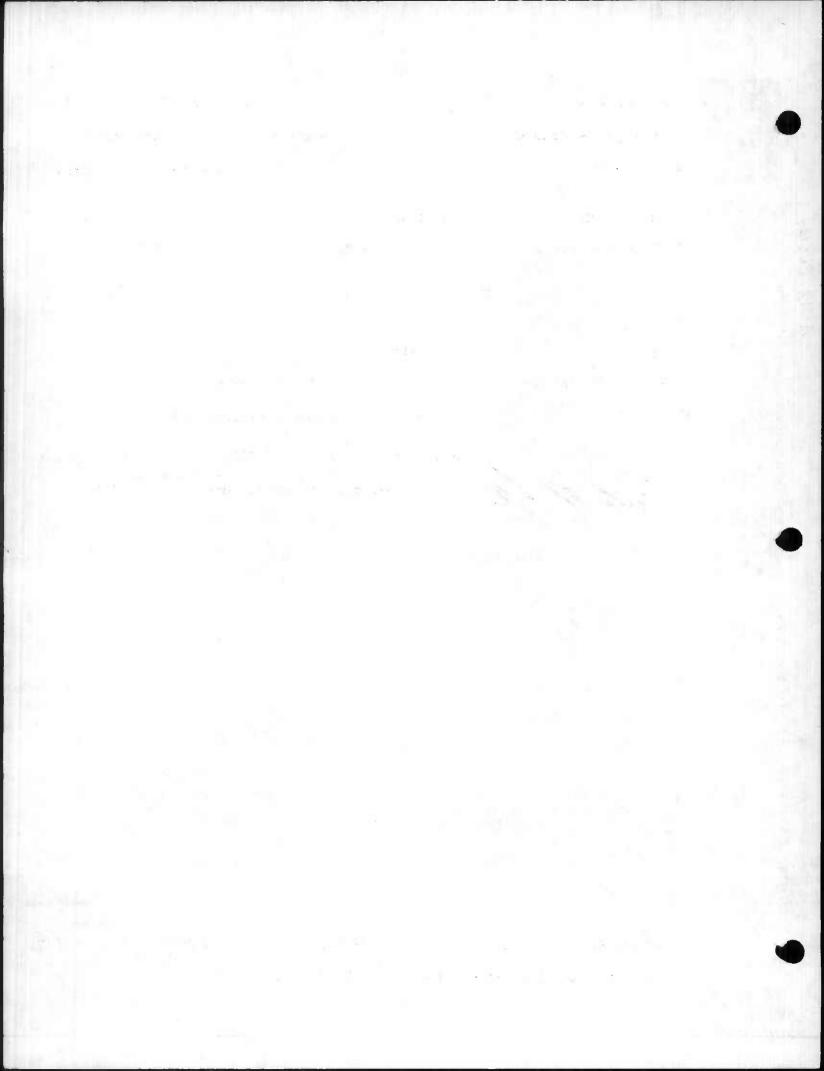
event, the Medical Examiner must be notified at

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth March 2, Day 999 **Physician** Anna R. Busby 7:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Augsburg Nursing Home Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/31/1906 Funerai 7. Age (In yrs. last birthday) 9. Birthpleca (State or Foreign Country) Maryland 1 □ M 2 🖫 F 92 Days Hours 212-03-2423 Yrs Director Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Ves 2 No N/A Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3407 Brendan Avenue 21213 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decadent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Completed by 3₺ Widowed 4 Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Tailor Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Frederick W. Hoffman Mary E. Mehring 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Haalth ar Important: If Item 27 is any injury or other trau Sharon McLemore 6414 Glenoak Avenue Baltimore, Maryland 21214 20b. Placa of Disposition (Neme of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 □ Donation 5 □ Other (Specify) St. Paul Violetville 3/8/99 Baltimore, Maryland 21. Signeture of Foreral Service Licensee 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one tause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Finel END STAGE ALZHEIMERS DEMENTIA 8 MONTHS disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown IXOF LATE EFFECT STROKE Be Completed by 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? HYPENTENSION 1 Yes 2 1 No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Maturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medicai 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH SIXTH Queice H45931 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MARYLAND ZIZO8 7220 PARK HEIGHTS AVENUE 31. Date filed (Month, Day, Year)
MAR 9 32. Registrer's Signature 1999

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month LUCITLE Crump 4e. Facility Neme (If not institution, give street end number, 1405 four 1999 march 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore dica 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 1□ M 2□XF MARYLAND 71 Yrs. 212-20-4319 Usuel Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits YYes 2 No MARYLAND N/A BALTIMORE CITY 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3314 ELLERSLIE AVENUE 21218 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7th grade College (1-4or 5+) HOME CARE PROVIDER HEALTH 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) SAMUEL TOLSON unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Wayne G. Crump/Son 3314 Ellerslie Avenue Baltimore, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State 3-11-99 OWINGS MILLS, MD 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST 21. Signature of Funeral Service Licens 22 Name and Address of Facility OWN COMMUNITY FUNERAL HOME 1206 W. NORTH AVENUE PA 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediete Ceuse (Final disease or condition resulting in death) unknown Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 ☐ Yes 2 No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Examiner pue physician s the buriel 68760 Physician/Medical Box P.O. 1 signed by t Records. Completed 9090 Division of Vital Be 10 Medical Certification: Aftar

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Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

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Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic lymphocytic leokemia Pleural effusion Bacteremia 25. Wes case referred to medical exeminer? Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA

28e. Date of Injury
(Month, Dey Year)

28b. Time of Injury
14 1□ Yes 2 No 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigetion 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 1xx Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.
21 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and menner stated. 29a. Certifier

State Registrar

ERHART

29c. License number

29d. Date signed (Month, Dey, Year) March Four, 1999

who completed cause of death (Item 23e) (Type, Print)

301 ST. PAUL Place Baltmore, MD 21202

SANDLA 31. Date filed (Month, Dey, Year)

29b. Signature and title of certifie

32. Registrer's Signeture

March 11 Arms 11

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If Under 1 Year

10f. Zip Code

Days

Months

MICHAEL

State of Maryland / Department of Health and Mental Hygiene 9

CALL DIGITIO	_
Physician	
/Medical	
Examiner	
	•

CADDEDETET ITEMS: #23 PART I, II, 27, 28A-F PER MEO Certificate of Death 1. Decedent's Name (First, Middle, Last)

CAPPARELLI

7. Age (In vrs. last birthday)

36

2. Date of Death 3. Time of Death Day MARCH 1999 10:50P.M.

4a Facility Name (If not institution, give street and number) CHURCH HOSPITAL 6. Sex. 1 → M 2 □ F 5. Social Security Number

MICHAEL

4b. City, Town, or Location of Death BALTIMORE

Min

If Under 24 Hrs.

Hours

4c. County of Death

Funeral Director

28a-f show

Directo

Funeral

λq

Completed

Be

Examiner

Physician/Medicai

by

Completed

Be

2

Certification:

Medical

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 end 2 should be filed within 72 hours after tent of Health and Mentel Hygiene. nt: If Item 27 Is marked other than "natural", or ite

traumatic avent.

other

0 Depertment Important: If

Maryland 21215-0020

Baltimore,

P.O.

Division of Vital

Usual Residence of Decedent 10a. State 10b. County

10c. City. Town or Location

8. Date of Birth (Month, Day, Year) 05-04-1962 9. Birthplace (State or Foreign NEW YORK

10g. Citizen of What Country?

MONMOUTH

139-68-7961

LONG BRANCH

10d. inside City Limits 1 ☐ Yes 2 ☐ No

10e. Street and Number

11. Marital Status

1 BAYVIEW COURT

07740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

USA 14. Race - American Indian. Black, White, etc.

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🖾 No If Yea, Give

College (1-4or 5+)

1 Yes 2 No Specify:

Specify: WHITE 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

(Give kind of work done during most of working life. DO NOT use retired) construction worker

16a. Decedent's Usual Occupation

BLAKE CONSTRUCTION construction

17 Father's Name /First Middle | ast)

RICHARD CAPPARELLI

18 Mother's Name (First Middle Maiden Surname)

EILEEN KERR

19a, Informant's Name/Relationship (Type, Print) RICHARD CAPPARELLI

FATHER 1 BAYVIEW CT.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LONG BRANCH, NJ

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cmetery

Date 20c. Location - City or Town, Stata 3/6/99 Staten Island, N.Y.

21. Square of Funeral Service Licensee

22. Name and Address of Facility Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Examiner

> and buriel-tran

physician certificate be

the

80 esn 10 deteched

signed by t

been

has page 2

certificate

this funeral

After

or Attending effector: Aff

24 hours e

To the I within 2

director

Immediate Cause (Final

disease or condition resulting in death)

ACUTE TOXIC REACTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

DIABETES MELLITUS

24a. Was an autopsy

24b. Were autopsy findinga available prior to completion of cause of death?

10 Yes 2□ No 26. Place of Death (Check only one)

2□ No

25. Was case referred to medical 1⊠ Yes 2□ No

27. Manner of Death

1 Natural

2 Accident

3 Sulcide

4 Homicide

5 Pending investigation

1 ☐ Inpatient ② ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Found: 3-2-99 28b. Time of Found:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? P 1 Yes

28d. Describe how injury occurred UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME

28f. Location (Street and Number of Rural Route Number, City or Town, State) 2124 E. FAYETTE ST., BALTO., MD.

29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

6 🖾 Could not be determined

O.C.M.E.

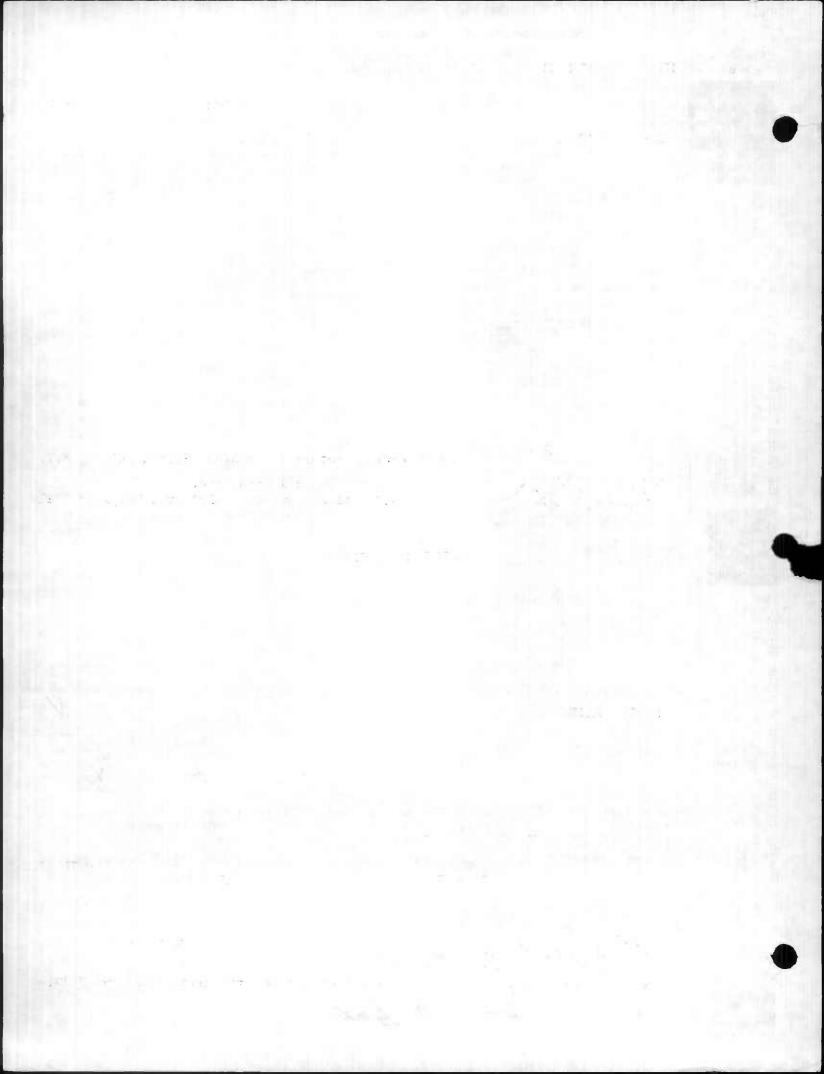
MARCH 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miking 1 HEUDORE 31. Date filed (Month, Day, Year) 1999

111 Penn Street, Baltimore, Maryland 21201 2. Registrar's Signature

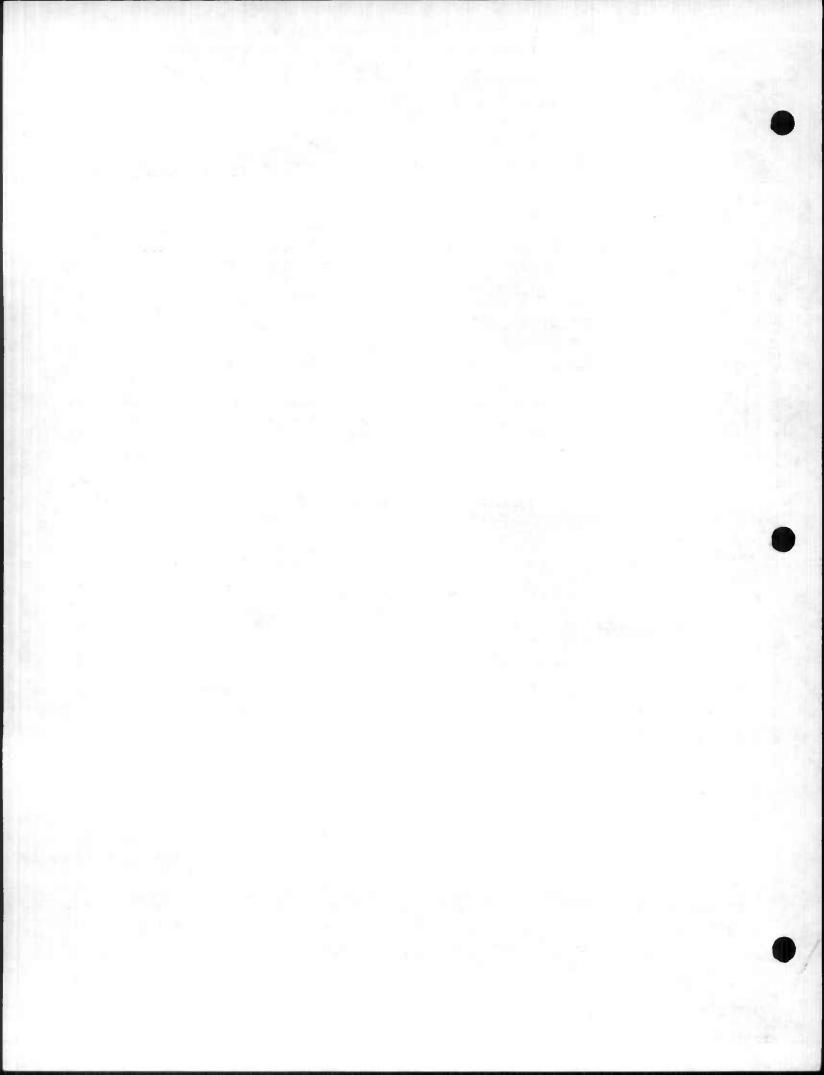
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

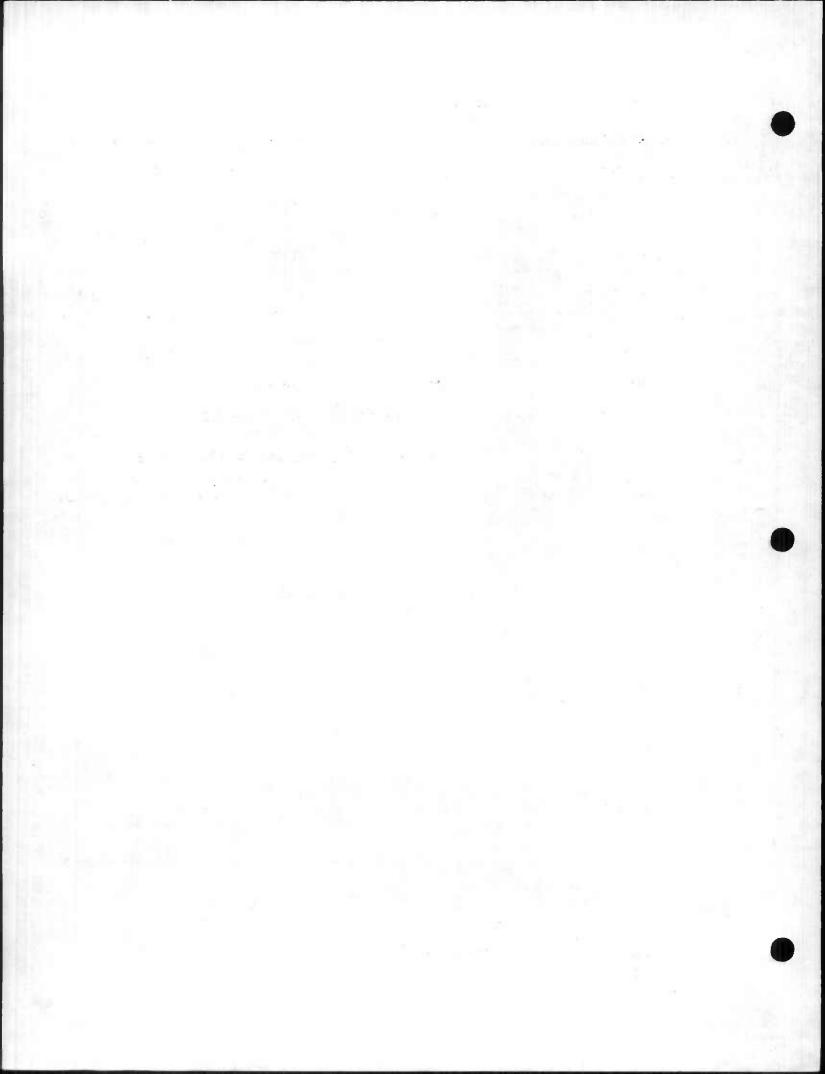
State of Maryland / Department of Health and Mental Hygiene

					Certif	icate of	Death		Reg. No.	0/3/3				
Physicia	n	1. Decedent's Nema (First, Middle, La.		1				2. Date of De		3. Time of Death				
/Medica			-	ohen			4. 05	marc	4 31	999 5:20 pm				
Examine	er	4a Facility Nema (If not institution, giv. Union Memoria	al Hospin	tal			Baltim	/		imore City				
Funeral Director		214-46 8 13)	ex 7. Age	92		Under 1 Yaa onths Days		(Month, De	y, Year) 8, 1907	9. Birthplace (Stete or Foraign Country) Baltimore, Mi)				
land a	1	Usuet Residence of Decedent 10e. Stete 10b. County		10c. City, To	own or Location	on				10d. Inside City Limits				
Mary Priest	tor	MD N/A		BA	LTIMOF	RE				1 Yas 2 No				
h with the	al Director	10e. Street and Number 4000 N. CHARLES	STREET #	1	Of. Zip Code	2121		10g. Citizen of W						
02(02)	by Funeral					Decedent of s, specify Cul	Hispanic Origin? () ban, Mexican, Pued Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE						
72 hours	eted	15. Decedent's Ed (Specify only highast gra	lucation da completed)	16	Sa. Decedent (Giva kind	's Usuel Occu	pation during most of wo	orking	16b. Kind of Bu	siness/Industry				
vithir within	Completed	Elementary/Secondary (0-12)	Coilege (1-4or 5-		(Giva kind of work dona during most of workil life. DO NOT use retired) HOMEMAKER				OWN	HOME:				
and 2 3 be filed intel Hygie d other; avent, tr	BeC	17. Fether's Name (First, Middle, Last)	. Fether's Name (First, Middle, Last)					Specify: WHITE 16b. Kind of Business/Industry OWN HOME The (First, Middle, Meiden Sumeme) A COHEN Ural Route Number, City or Town, State, Zip Code) LINGFORD, PA 19086 Deta 20c. Location - City or Town, State 3/5/99 BALTIMORE, MD LEVINSON & BROS., INC. ROAD — PIKESVILLE, MD 21208 c or respiratory errest, Approximate Intervel Between Onset and Death						
View Mend	To	ARCHIBOLD		SY	KES		RHON	A		COHEN				
- 5 % C		19e. Informant's Neme/Reletionship (CAROL DEROW / D												
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Balti permit. I Departm Importati any Injui		21. Signeture of Funarai Service Licen	500		22. Na	nme end Addr	ess of Facility SO	L LEVINS	ON & BRO	OS., INC.				
		23a. Part1. Enter the disease, or comp shock, or heert failure. List only	olications that caused	the daeth. D						Approximate Intervel Between				
Physician /Medical Examiner		Immediata Ceuse (Finei diseese or condition resulting in death)	Cong							Onset and Death				
	ē	Tooling II oddin	Detail	Due to (or as	a consequen	ce of):	acalin. la	coulos	A : con	se 710 years				
cete be executed physician and the burial-transit	Examiner	Sequentially list conditions,			e consequen		raiovo	11 CU Jav	Disca	Je 110 years				
50, be exection at ourisel-t	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c											
	edical	thet initieted events rasulting in death) Last	C	ua to (or as	a consequen	ce of):			71					
Box 6 eath certif	Physician/M	Charles Inc.	d											
O death	SICIE	Part II. Other significant conditions co	ontributing to death but	t not resulting	in the under	tying cause g	iven in Pert I.	23b. Did 1	tobacco use con	tribute to the cause of death?				
	by Phy	Artic Ste	enosis					10	1 Yes 2 No 3 Probably 4 Unknow					
of Vital Records, P.O Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be deteched	Completed	Pneumoni.					4a. Was an autopsy performed? 24b. Were autopsy finding eveilable prior to completion of cause of deeth?							
I Re law	E							101	res 2000	1 Yes 2 No				
f Vital F vsicien: The s certificate director, peg		25. Wes case referred to medical examinar?						eth (Check only o	ne)					
of Vita Physician: this certific real director,	0	1 Yes 2 No	Hospitel: 1 Pinpatier			SLI DOA		Home 5 ☐ Resid						
After funer	tion	1 ☑Netural 5 ☐ Pending	28e. Dete of Injury (Month, Dey	Injury	ime of 28c. Injury et Work? M 1 Yes 2 No			28d. Describe how injury occurred						
Division or Attending after deeth. Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		factory, office		treet and Number or Rural Route Number, n, State)								
	edicai C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best of liner: On the basis of and manner stet	exemination a	ge, deeth occ and/or investi	curred at the tigation, in my	ime, date and plac opinion, death occ	e, end due to the urred et the time,	ceuse(s) end me dete and place, a	nner es steted. and due to the ceuse(s)				
vithin Fo the		29b. Signature and title of certifier	and mainter alor	1.77			se number		29d. Date signed	(Month, Dey, Year)				
. , , ,		Marc Q. Y.	magnus	JA	0	0	1722	5	Marc	43,1999				
10		30. Name and address of parson who o		ath (Item 23s	(Typa, Prin	3300	1 St. #	131 R	0/+	43,1999 MD 21218				
State	e	31. Dete filed (Month, Dey, Yeal)*	32. Registra		4	Inou	2)	-/ /3						



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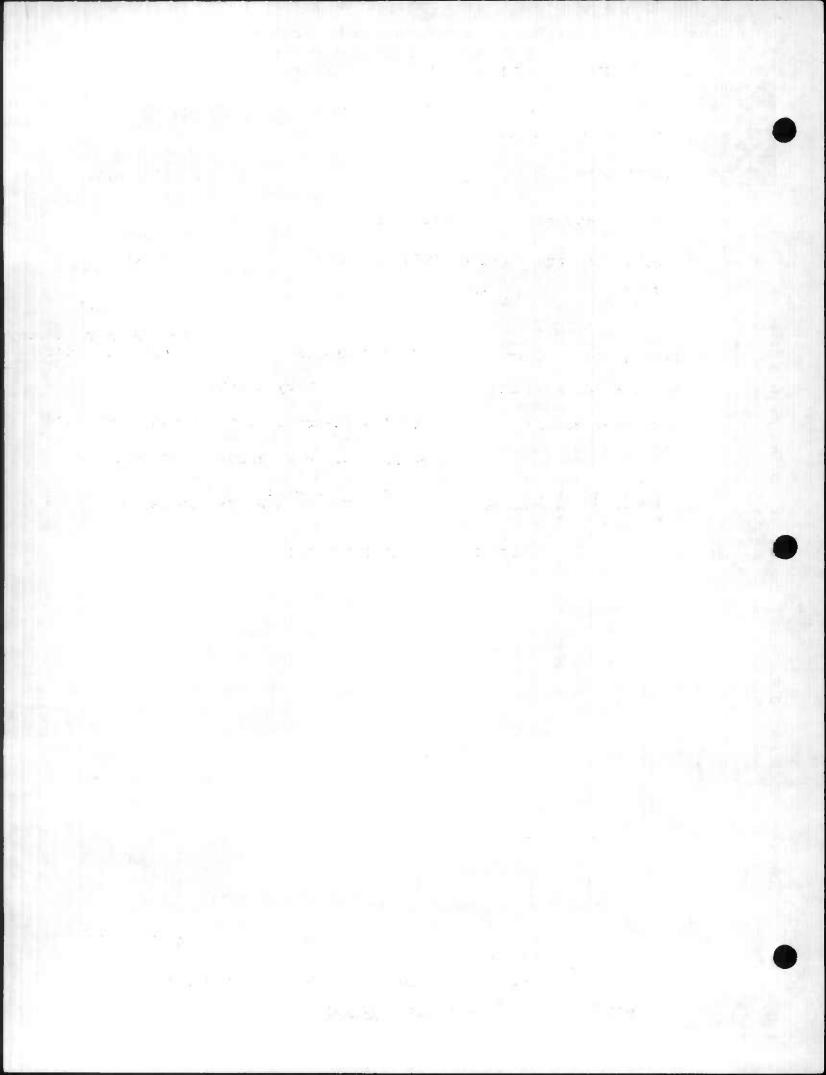
State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death ,^{Dey}1999 MARCH 2, **Physician** SARAH BESSIE CALSTEIN 4:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 32 BROOKBERRY DRIVE, REISTERSTOWN BALTIMORE If Under 1 Yeer | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Days Hours 1 M 2 F Yrs Director 212-18-4891 76 MAR. 9, 1922 MD Usual Residence of Decedent 10a Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE REISTERSTOWN 1 Yes 2X No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Berns 23a or 32 BROOKBERRY DRIVE, APT. 1A 21136 U.S.A. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. 72 hours after 1 Yes 2XXNo 1 Never Merried 2 Merried 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE à 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working tite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 SALES CLERK BAKERY permit. Pages 1 and 2 should be lile.
Department of Health and Mental Hyp, important: If Ilem 27 is marked other any Injury or other transmented other 9069. Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be JOSEPH **HESS** CAROLINE OSWITZ Lo 19a. Informent's Neme/Reletionship (Type, Print)
DAVID CALSTEIN / HUSBAND 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 BROOKBERRY DR. #1A - REISTERSTOWN, MD 21136 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location · City or Town, State 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete MARYLAND VETERANS CEMETERY 3/5/99 OWINGS MILLS, MD 4 Donetion 5 Other (Specify) 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Hear Examiner Dusto (or es a consequence of): Examiner 1-1sician and burial-transit CVANC The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of physician s the burial Box 68760. Physician/Medical Due to (or es e consequence of): attending for use as 950 signed by the a d be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? page 2 1 Yes 2 No certificate 1 Yes 2 No Division of Vital i or Attending Physician: other death. Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Neturel 1 Yes 2 No investigation 2 Accident 6 Could not ba 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide n 24 hours effer a Funeral Dire eletely filled in E 29a. Certifier edical 1 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) and manner steted. To the To the F 29b. Signeture end title of certifier 29c. License numbar 29d. Date signed (Month, Dev. Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) MAIN 750 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar MAR 9



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

LD K. CO	LEMAN JR. ITEM 1. Decedent's Name (First,			7, 28A	-F Cei	rtifica	te of	Death		2. Date of Da	ath		3. Tima of Death	
Physician	Ronald		. Coleman Jr				r. MARC			Day 5. 199	Year	1233 PM		
/Medical Examiner	4a Facility Nama (If not inst LIBERTY MED)	itution, giva :	street and number	street and number) 4th					4b. City, Town, or Location of Dea BALTIMORE					
Funeral Director	5. Social Security Number 216-02-615	6. Sex	7. M 2 F	Age (In yrs.	last birthday) Yrs.	If Under	or 1 Yaar Days	If Under Hours	24 Hrs. Min.	8. Data of Bir (Month, Da	y, Year)	9. Birthp Cour N • 1	eleca (Stata or Foraign etry)	7
	Usuel Residenca of Decede	nt					1			04 20	, 05			
rector	10a. Stata 10b. C				ty, Town or Lo							1	0d. Inside City Limits 1 ☐ Yas 2 ☒ No	
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百	10e. Street and Number					101. 2	lp Coda				10g. Citizan of		ntry?	
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Funeral Director	Naver Married 2		Armed Force	s?						ecify Yas or No Rican, atc.)	Bla	ck, Whita,		
by	3 ☐ Widowed 4 ☐ Div		If Yas, Giva 1 ☐ Year or Datas:			1 🗆 Yas	2 No	Specify:			Specif		ack	
Be Completed	15. Dad (Specify only)	edant's Educ	cation		16a. Deced	dant's Usi	ual Occup	ation	t of work	ina	16b. Kind of B	usinass/In	dustry	
nple	Elementery/Secondary (0		College (1-40	or 5+)	lifa. I	va kind of work dona during most of work. DO NOT use retired)			t or work	Pre		resident of Asso		
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Be	17. Fathar's Nema (First, Mi						18. Mother's Nemary St				Meldan Suman	imama)		
2	Ronald K. C				40h Mailin	an Antolesa	- Chron	_			er, City or Town	Ctata 7is	Codel	
semit. Pages 1 and 2 should be filed within begarment of Health and Mental Hygiene. mportant: If item 27 is marked other than ny injury or other traumatic event, the Mace. To Be Comp	19e. Informent's Neme/Rela					-					olumbi			
	Mary Peay- 20a. Mathod of Disposition	Mothe	3.4	20b.	Place of Dispo	sition (Na	ama of		11 52	Data	20c. Location			
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	11 () 0	1		()				H Wes					21215	
budel-transit al Examiner	23a. Fartt. Enter the disease shock, or heart failure. Immediate Ceuse (Final disease or condition resulting in death)	а		THANOL	AND NAR	COTIC	INTOX					1	Intervel Between Onset and Daath	
Examiner	Sequantielly list conditions, if any, laading to Immadiate causa. Entar Undarlying Couse (Disaasa or Injury	antielly list conditions,			b. Dua to (or as a consequence of):									
dical	Couse (Disaasa or Injury that Initiated events rasulting in death) Last	1 °	c Due to (or as a consequance of):											
Physician/Me	Part II. Other significant co	nditions con	J	but not ras	ulting in the u	ndarlving	causa niv	an in Part I		23b. Dld	tobacco use co	ntribute t	o the cause of death	?
/ Phys												2 No 3 Probably 45 Unknow		
Completed by											an autopsy ormad?	av	ara autopsy findings railable prior to emplation of causa death?	
E O										125	Yes 2□No	1/	S¥as 2□ No	
BeC	25. Wes case rafarred to m	adical						26. Plece	a of Deat	th (Check only o	one)	1		
To Be Com	axaminer? X⊠ Yas 2□ No	Н	lospital:	itiant 20	XER/Outpetier	nt 3 🗆 🗅	Oth	nar: 4□ Nu	ursing Ho	oma 5 Rasi	dance 6 🗆 Ott	nar (Speci	(y)	
	27. Mennar of Daath 1 ☐ Natural 5 ☐ P	anding	28e. Date of I	njury Da <i>y Year)</i>	28b. Tima or		28c. Injui Wor	ry et rk?			how injury occu	rred		
catic	2 Accident	vestigation	Found:	9	UNKNOWN "			Yas 2 No		UNKNOWN				
	3 ☐ Suicida 6 X C 4 ☐ Homicida	ould not be etermined	28a. Pieca of Injury - At homa, ferm, street, factory, office building, atc. (Specify) UNKNOWN			City or To			n (Street and Number or Rural Routa Number, Town, Stata) IKNOWN					
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completely filled in by the	29b. Signature and titla of o	ertifiar				2:	9c. Licans	sa number	-		29d. Data signe	ed (Month,	Day, Year)	_
	Denn	in) a	work				0.0	.M.E.		MARCH 6, 1999				
	Denni's J.	Chw					eet,	Balti	more	e, Maryl	land 212	201		
State	31. Date filad (Month, Dey, MAR 9	1999	32 Ragi	strar's Sign	atura 4	1	uls	,						

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) **Physician** James Chmielewski /Medical 4e Fecility Name (If not institution, giva street end number) 4b. City. Town, or Location of Deeth **Examiner** Center Hospital Co Kosedale Franklin Square f Under 24 Hrs. 5. Social Security Number **Funeral** Days Months 1 MM 2□ F Hours 216-20-9682 84 Director Usual Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "naturef", or items 23s or 28s-f show traumstic event, the Medical Examinat must be notified at MD Harford Director Joppa 10e Street and Number 10f. Zip Code with 620 A Magnolia Rd 21085 Funerai 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Nov 14 1914 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country?

USA

1999

4c. County of Death

Reg. No.

Day

2. Date of Death

8. Dete of Birth (Month, Day, Year)

Month

Morch

12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Maritel Status 1 Never Merried 2 Married 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highast grada complated)

1 ☐ Yes 2 No Spacify: Specify: White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry

Elementery/Secondary (0-12) College (1-4or 5+) 6 17. Father's Neme (First, Middle, Last)

Mechanic Automobile 18. Mother's Name (First, Middla, Maidan Sumama)

Joseph Chmielewski 19a. Informant's Name/Relationship (Type, Print)

Alexandria Mik 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)

Marie Chmielewski 20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

620 A Magnolia Rd

Joppa, MD 21085 Date 20c. Location - City or Town, State

20b. Place of Disposition (Nama of cematery, crematory or other place) Metro Crematory

March 1999 Catonsville, MD

21. Signature of Funeral Service Licenses onn 23e. Part1. Enter the discusse, or complications that caused the country arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility
Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222

Immediate Cause (Finel diseese or condition resulting in death)

þ

Completed

Be

· Respiratory Acidosis, Progressive Hypoxemia Due to (6r es e consequence of):

Approximate Intervel Between Onset end Death 7 hours

3. Time of Death

Baltimore

14. Rece - American Indian,

Black, White, etc.

Birthplace (Stata or Foraign Country)

3:20 p.m

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Obstructive PNeumonia Due to (or as a consequence of)

· BTONC Carcinoma hogenic Due to (er es e consequence of):

Part It. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

/wife

Congestive Heart Failure Hypothyroidism

23b. Dtd tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No

Hospital: 1 Inpatient 2 □ ER/Outpatlent 3 □ DOA

28c. Injury et Work? 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 5 Pending

6 Could not be determined

28a. Date of Injury (Month, Day Year) investigation

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 No

26. Place of Death (Chack only ona)

28f. Location (Straat and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steled.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D43956 29d. Date sloned (Month, Day, Year) 3/8

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

William Stinnette 9000 Franklin Square Drive, BAltimore MD. 21237 M.D.

31. Date filed (Month, Day, Year)
MAR 0 9 1999

32. Registrar's Signature

Registrar DHMH 16 Rav 6/95

P.O. Box 68760 Records,

Thmielewski

1 and 2 should be filed with Health end Mantel Hygiene.

Health em 27

Pagas ō

item 27 other t

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Physician /Medical

Examiner

physician and the burial-transit

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been signed by the should be detached

r this certificate hes

funeral

Aftar

after death. Director: Aft

24 hours a

Examiner

Physician/Medicai

Completed by

Be

2

Certification:

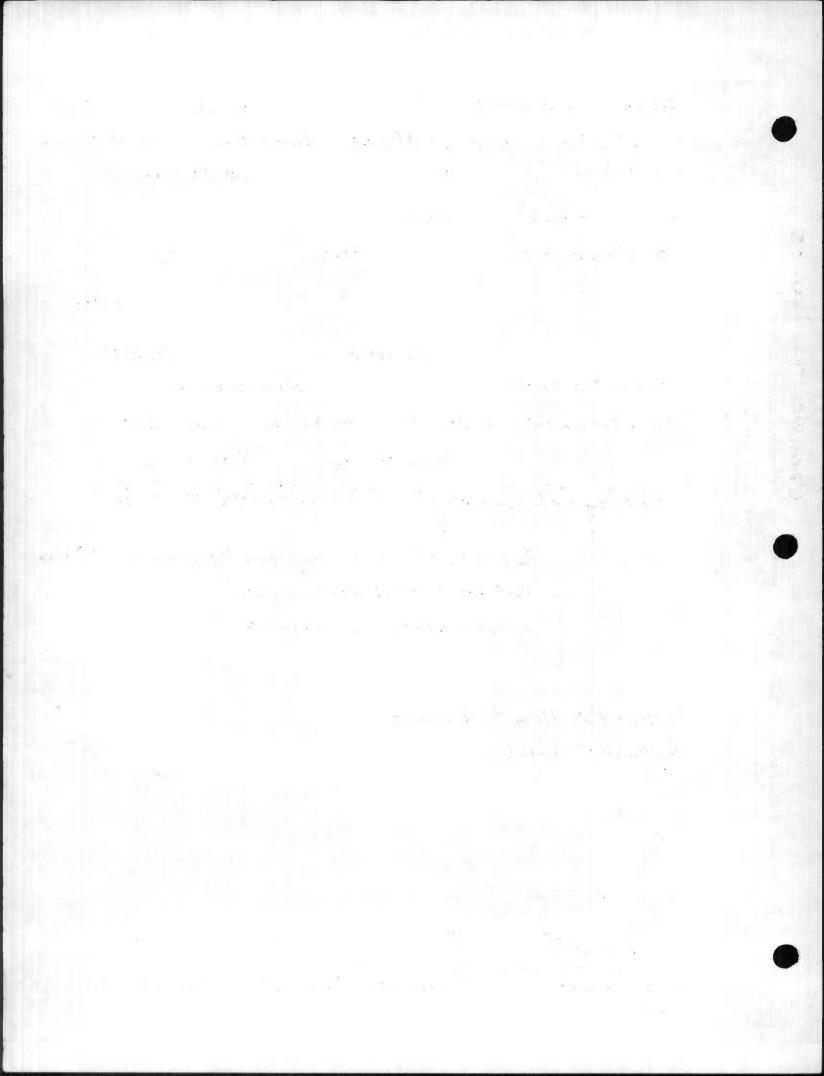
Medicai

State

law requires that the death cartificate be executed

Division of Vital Hospital or Attending Physician: 24 hours after death.

To the Hosp within 24 hor To the Fune completely fi ast

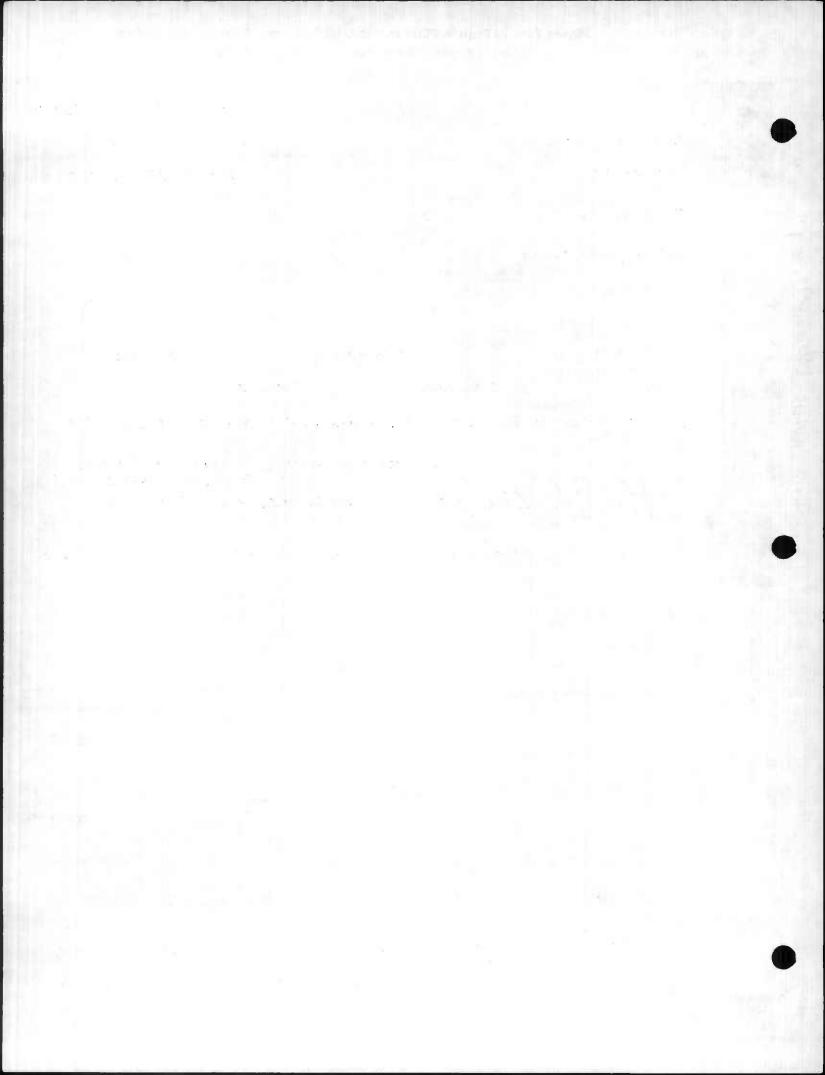


State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Year **Physician** CAVALLO March 7, 1999 8:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Nursing Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Sociei Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Deys Min 1□ M 200 F Yrs. 76 212-12-6465 **Director** Dec. 21,1922 Maryland Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Examined payed by notified at Maryland Baltimore Parkville 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3023 Edgewood Avenue 21234 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White þ 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event edge. Elementary/Secondary (0-12) College (1-4or 5+) 12 yr S Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Manuel Provenzano Concetta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael J. Cavallo, Jr. - Son 810-D Wilson Point Road Baltimore.MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 YBurial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Holy Redeemer Cemetery 3/11/99 Baltimore, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part 1. Enter the disease, or complications that cars shock, or heart failure. List only one cause on each he death. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 2/2 years ASTATIC colon Examiner Due to (or as a consequence of) Examiner physician end the burief-transit thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by 1 Yes 2 No 3 Probably 4 Unknown þ The law requires 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy performed? Completed hes certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury at Work? After 5 Pending 1 Natural 1 Yes 2 No Investigation 2 Accident death. 24 hours after deat Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifie MArch 8, 1999 cause of death (Item 23a) (Type, Print) 30. Name and address of person who compl N. Charles St. Balto. md 21205 1999 Nach Registrates Signature 6701 State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

Registra



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Deeth 3. Time of Death **Physician** 1999 Robert F. Crooks 11:30am March 4, /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Hopkins Bayview Baltimore n/a If Under 1 Year If Under 24 Hrs. Birthpleca (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. lest birthdey) 8. Date of Birth (Month, Dev. Year) Months Deys Hours Min 1 X M 2 □ F Yrs. 80 5-13-1918 182-05-0107 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 No Yes 2 No MD n/a Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 432 S. Elrino Street 21224 USA Funeral 12. Was Decedant Ever In U.S.
Armed Forces? A irfor
1 ⊠Yes 2 ☑ Nô
1 □ Yes 3 □ Nô
1 □ Yes 2 ☑ No Specify: 14. Rece - American Indien. 11. Marital Status Bleck, White, atc. 1 □ Nevar Married 2 □ Married Specify: White by 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada complated) (Giva kind of work done during most of working life. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Bethlehem Steel Co. 12th 18. Mother's Name (First, Middle, Maiden Sumema) 17. Fether's Name (First, Middle, Last) Be Philip F. Crooks Anna I. Jones 19e. Informent's Neme/Reletionship (Type, Print) nephew 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 14651 S.W. 141st Place, Miami, Florida 33186 Bruce W. Carter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from Stete 3/9/99 Baltimore, Maryland Sacred Heart of Jesus 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Joseph N. Zannino Jr. Funeral Home 21. Signeture of Funerel Servica Licensae 263 S. Conkling St. Baltimore, Maryland 21224 anneal week 23e. Pert1. Ether the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only be cause on each line. Approximata Intervel Between Onset end Deeth Immediate Cause (Final Emphysema disaese or condition resulting in deeth) 10 years Due to (or es e consequence of) Examiner Sequentielly list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2□ No 3□ Probably 4□ Unknown þ 24b. Were autopsy findings aveileble prior to complation of causa of deeth? 24a. Wes en eutopsy Completed 1 Yes 2 No 1 ☐ Yas 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☑ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and menner stated 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Dev. Year) D15408 3/6/99 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Denis MacDonald 2801 Hudson St., Baltimore, Maryland 21224 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature

State Registrar

MAR 9

Funeral

Director

"natural", or items 23a or edical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena.
Important: if item 27 is marked other than "natural", or iten eny injury or other traumatic event, the Medical Exercises page.

Physician /Medical

Examiner

physician and the burial-transit

attending p

signed by the a

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aftar death Director: A

To the Hospital or within 24 hours aft To the Funeral Di complataly filled in

death.

The law requires that the death certificate be axecuted

Box 68760.

P.O.

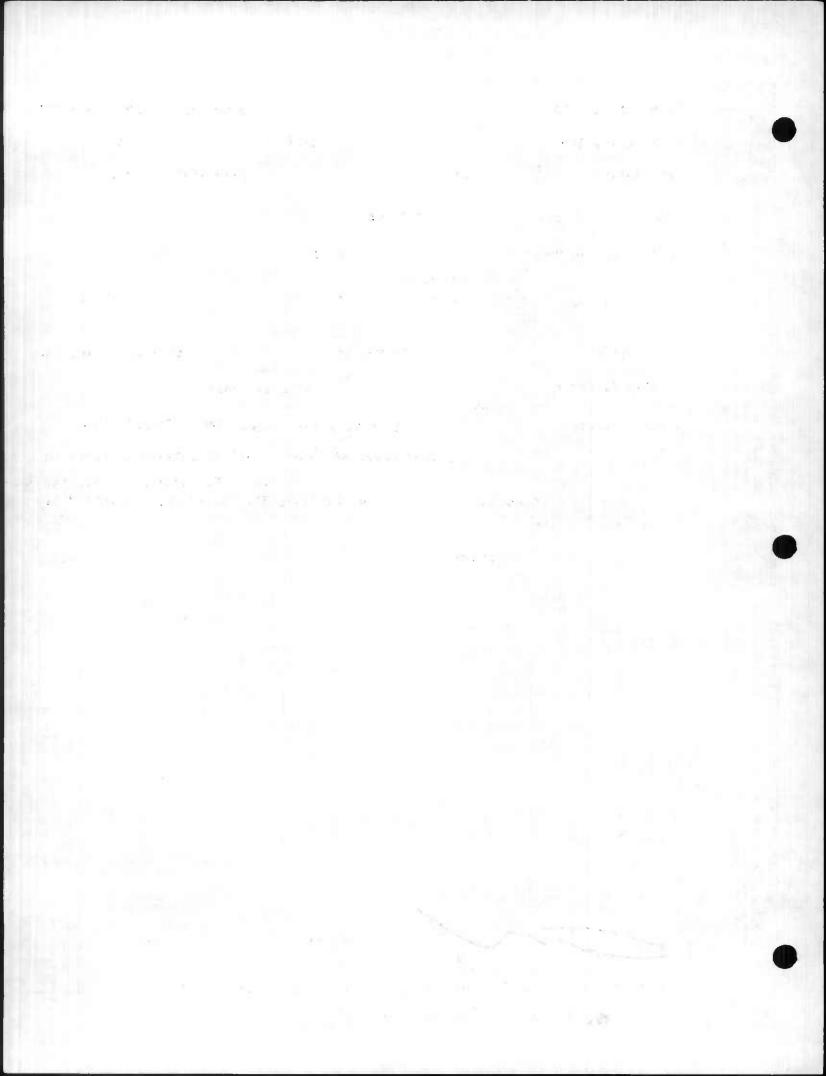
Records,

Division of Vital or Attending Physician:

Baltimore,

with the Maryland r 28a-f show

death



the death certificate be executed P.O. Box 68760. Division of Vital Records. or Attending Physician: after death. 24 hours a Hospital

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death

State Registrar

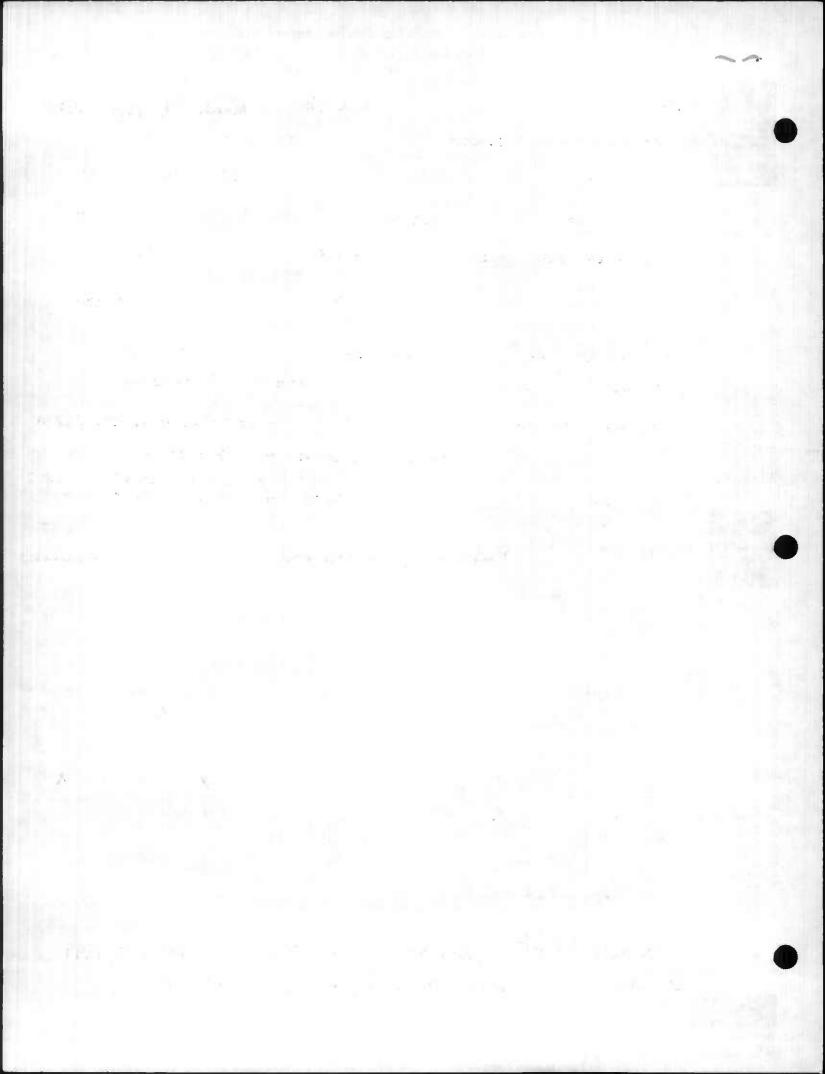
Street 32. Registrer's Signeture

Resident

completed cause of deeth (Item 23a) (Type, Print) Baltimere, Manyland

RES-000

March



that the death certificate be executed Box 68760. Division of Vital Records, P.O.

physician and the buriel-trensit signed by t has To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Physician

/Medical

Examiner

Director

Funeral

by

Funeral

Director

the Meryland

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Merylen Department of Heelth end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, the Med on Examine must be notified anone.

Physician /Medical

Examiner

Examiner

Physician/Medical

P

Completed

Be

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Certification:

29a. Certifier

Baltimore, Maryland 21215-0020

State Registrar

29b. Signatura and fitla of certifian

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 30641

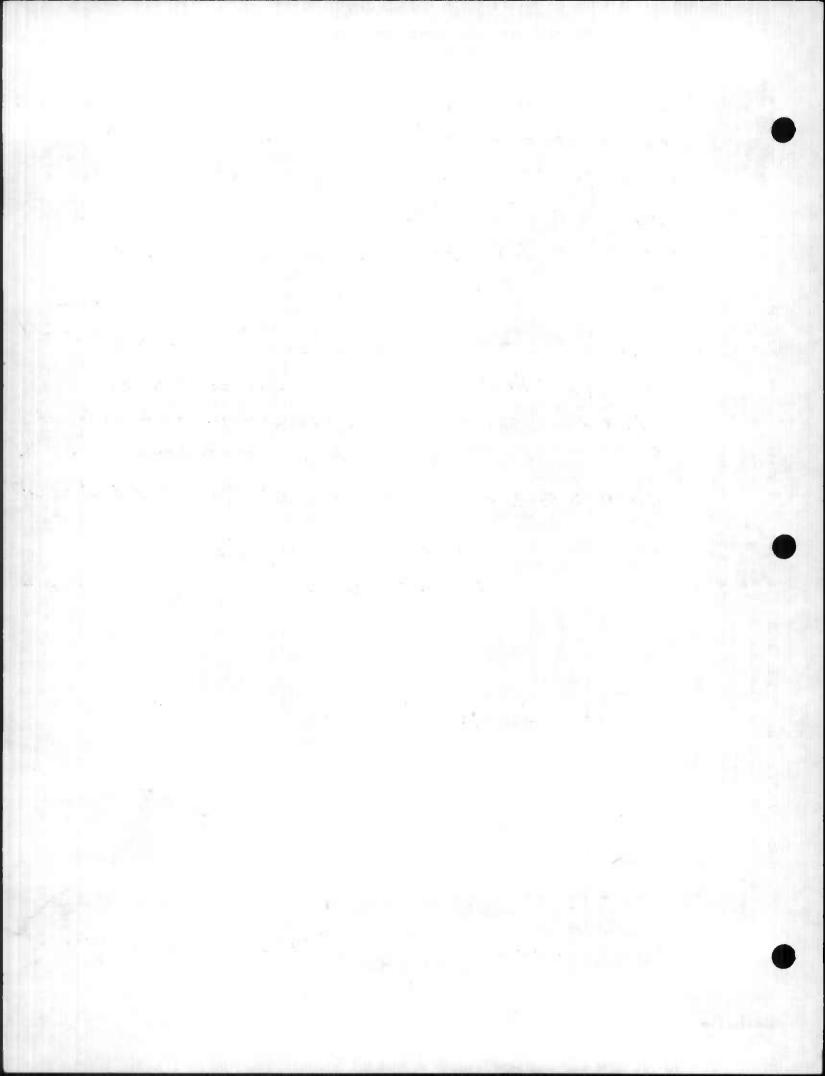
29d. Data signed (Month, Day, Year) 34 arch 815 1988

30. Nama and addrass of person who complated causa of death (Item 23e) (Type, Rrint)

821 n. Eulen SABARTAI RAMESL

31. Data filed (Month, Day, Year) 32. Registrar's Signatura

1999 MAR 9

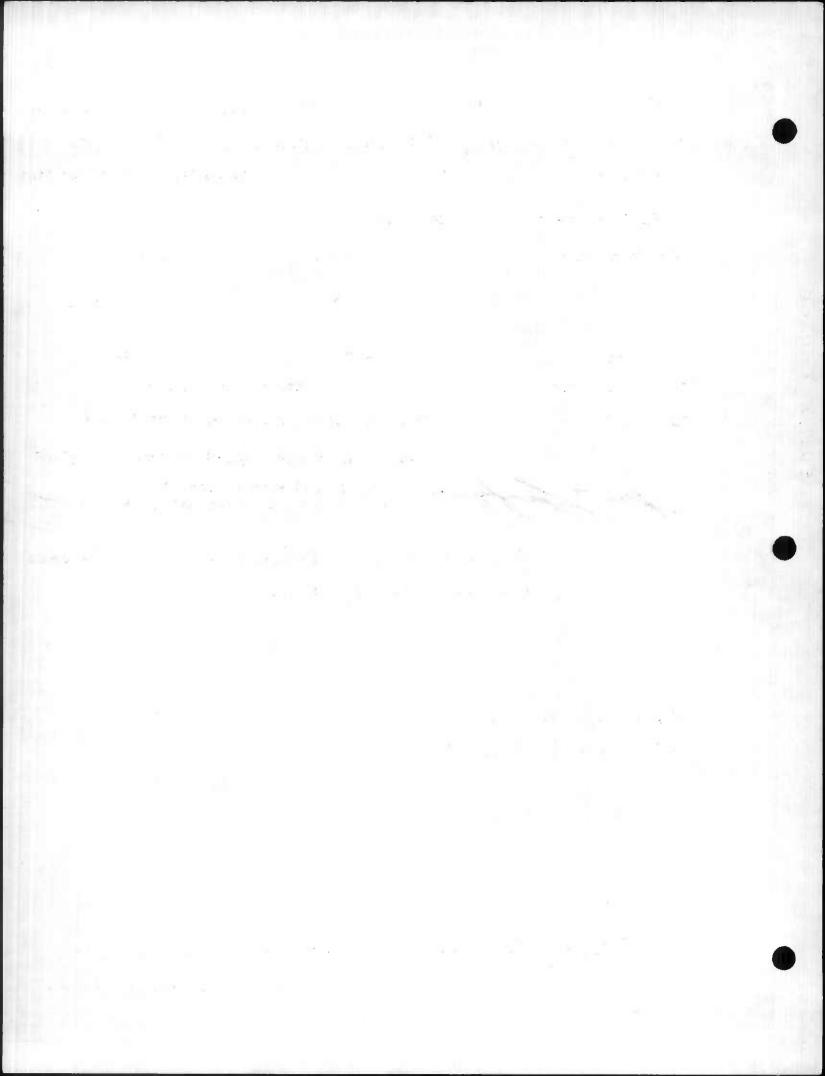


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Ruth Collier Evelyn MARCH 4:10 P.M. 1999 /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva streat and number) Examiner Rosedale if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Ago (In yrs. last birthday) If Undar HOSDITAL BAITIMORE FRANKLIN PUARE If Undar 1 Yaar Birthplace (Stata or Foreign Country) 5. Social Security Number 6 Sax **Funeral** 1□M 20 F Months Days Director 247-40-9532 March 11,1927 South Carolina Usual Rasidanca of Dacedan the Maryland 10c. City, Town or Location 10a Stata 10h County 10d. tosida City Limits 7 is marked other than "natural", or itams 23a or 28a-f show trsumatic event, the Medical Examerer must be notified at 1 Yas 2 No Baltimore Maryland Baltimore Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? death with 36 Lockett Court 21221 U.S.A. 14. Raca - American Indian, Black, Whita, etc. 12. Was Decedant Ever in U,S. Armad Forcas? 1 ☐ Yas ②ONo It Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Maritai Status 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas ②O(No Specify: Specify þ 3 XWidowed 4 □ Divorced White Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15 Decedent's Education (Specify only highast grada complated) Elamentary/Secondary (0-12) Coilaga (1-4or 5+) House Wife Own Home 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pages 1 and 2 should be f C. Owens Joseph Owens Evelyn R. 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code) 19a. tntormant's Name/Ralationship (Type, Print) int of Health a t: If Itsm 27 is y or other tra 36 Lockett Court, Baltimore, Maryland 21221 Edwin B. Collier 20b. Place of Disposition (Nama of camatery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval trom Stata permit. Page Department of Important: If any Injury or Holly Hill Mem. Gardens 3/8/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signature of unaral Sarvice Licensee Bruzdzinski Funeral Home, P.A. 23a art1. Enter the dissess, or complications that causad the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. 1407 Old Eastern Avenue, Essex, Maryland 21221 **Physician** /Medical Immadiata Causa (Final · Acute Myocardia InfARCTION 2 weeks disaasa or condition Examiner Examiner Disease ORONARY ARTERY physician and the burial-transit that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or injury that Initiated evants rasulting in daath) Last Dua to (dr as a consaquanca of); Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of): USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Preumonia 1 Yes 2 No 3 Probably 4 Unknown AspiRATion Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Izheimers page 2 2 NO 1 □ Yes 2 □ No 1 ☐ Yas certificate Hospital or Attending Physician: 25. Was casa ratarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 10 this funeral 27. Mannar of Daath 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Yaar) 28b. Tima of 28d. Describe how injury occurred After 5 Panding Invastigation Natural 2 Accidant death. 1 ☐ Yas 2 ☐ No after death 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At homa, farm, street, tactory, office building, atc. (Specify) 4 Homloida 24 hours of Funeral 12 Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and place, and due to the causa(s) and menner as steled.
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the causa(s) and manner stated. 29a. Cartifiar Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Data signed (Month. Dav. Year) 29b. Signature and title of certifiar 29c. Licansa number MARCH 3, 1999 30. Neme end eddress of person w impleted cause of deeth (Item 23a) (Type, Print) DA, MARCO ZAMORA 31. Data tiled (Month, Day, Year) MAR 0 9 1999 9000 FRANKlin SQUARE DR. BAITIMORE, MARYLAND 21237

32 Ragistrar's Signatura

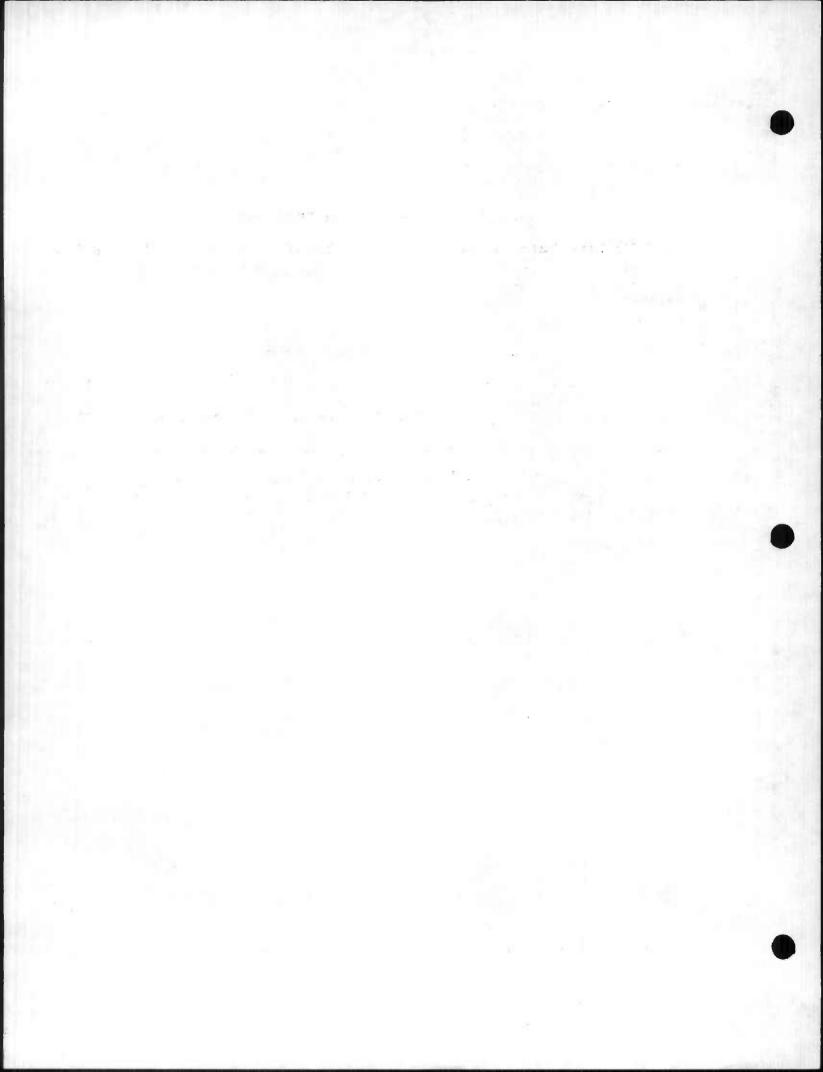
State Registrar

Evelyn



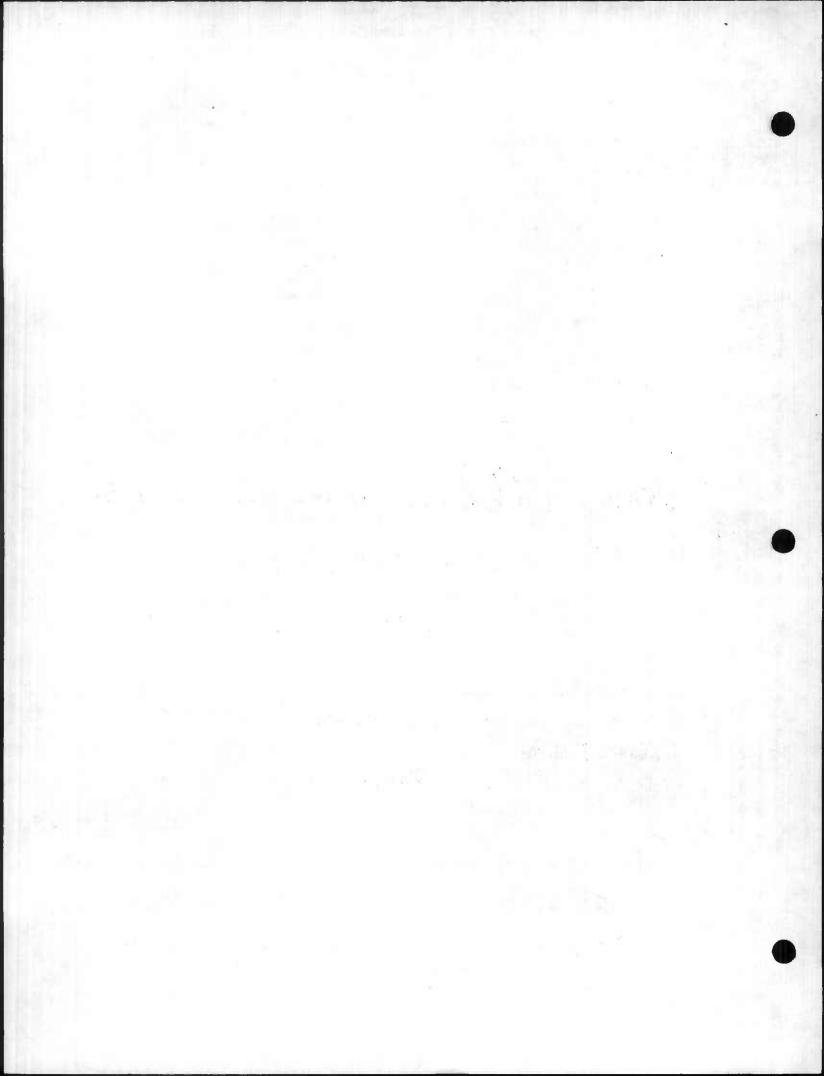
State of Maryland / Department of Health and Mental Hygiene Q Q 7 2 Q I.

						Certifica	te of	Death	Re	a. No.	U	1304	
	S		1. Decedent's Name (First, Middle, Las	ot)					2. Date of Death Month	Day	Yeer	3. Time of Death	
	Physicia /Medica	-	Joseph A. Drur	y, Jr.					March		999	7:10am	(
	Examine		4a Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·				4b. City, Town, or	Location of Death	4c. County	of Death		
			4023 Hollins F	-			1 V	N/A	T	Ba	ltim		
	Funeral Director		210 10 0000	9X 7. Age (In yrs. 74		Yrs. Month	or 1 Year s Days	Hours Min			9. Birthp Cour 4	place (State or Foreign htry) MD	,
	pue **		Usual Residence of Decedent 10e. State 10b. County	10c. Cit	y, Tow	n or Location					1	0d. Inside City Limits	_
	ith with the Marylar 23a or 28a-f ahow	Director		altimore				Maryla				1 ☐ Yas 2 ☐ No	
	23a or								10g. Citizen of What Country? United States				
5-0020	urs a	by Funeral	11. Marital Status 1 □ Never Merried 2 □ Married 3□ Wildowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? No If Yes, Give Year or Dates: WW	avy	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, € 1 ☐ Yes ♣☐NO Specify:		Specify Yes or No- to Rican, etc.)		ck, White,	en Indian, etc. ite		
5-0	72 ho	ete	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a.	Decedent's Us	vork done	during most of wo	rkina 1	6b. Kind of Bu	usiness/Ind	dustry	
2121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retire	ທີ່ k Drive	California	Transportation			
D			17. Father's Name (First, Middle, Last)		J	1	LIUC		me (First, Middle, M.	aiden Sumem	ne)		
lar		o Be	Joseph A. D	rury, Sr.				Vio	1a (Unkno	own	Maiden Na	me
ary	short and h		19a. Informant's Name/Relationship (7	Type, Print)	19b	. Mailing Addre	ss (Street	and Number or R	ural Route Number,	City or Town,	State, Zip	Code)	
Z,	and 2 alth 27 l		Loretta M. Dillow	/ Daughter	1:	246 Dor	is A	venue, B	altimore N	Marylan	nd 2	1230	
altimore	Peges 1 nent of He nt: If Nam nry or oth		20a. Method of Disposition 1 Burlei 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	emeter	Disposition (Nay, cremetory of Park	other pla			Oc. Location - Balt:		own, State Maryland	
Balti	permit. Departminportal		21. Signature of Funeral Service Licen	seeVictor P. Do	da,	Cha	rles	L. Steve	ens Funera	al Home	e, In	yland 212	30
			23a. Pert1. Enter the disease, or comp	plicetions that caused the deat	h. Do i						FIGI	Approximete	50
N	Physician		23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.									Onset and Death	
	/Medical	Immediate Cause (Final disease or condition as METASTATIC LIVER CA/LIVER FAIL									-	1 month	
	Examiner		resulting in death)	Due to (c	or as a	consequence o	f):	1				- /	
-	Da ts	를		6 LIVER	CAT	NER					ĭ	9/98	
	be executed sloian and bunal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) c. PAROX Y.SMAL ATRIAL FIBRILLATION 2/26 /										
9	physician the buris											2/26/90	2
68760	rificate be ext ng physician a as the burial	edica	resulting In death) Last	0							1	10 -	
Box	anding use a	2		a PROSTAL	70	MI	TRA.	L VITU			00	1968	p-4p-4p-
	the st o	2	Part It. Other significant conditions co	C K CY AT R	ulting in	the underlying	AMO O	my IN Part I	23h Did toh		179	75 (c) the cause of death	?
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	s the	DY.	HIPATITIS										
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ta	certificate rector, pag	9	25. Was case referred to medical	31111163	-			26. Place of De	ath (Check only one			2 100 1002	
2		0	axaminer? 1 ☐ Yes - Q CLNo	Hospital: 1 Inpatient 2	ER/Ou	tpatient 3 I	DOA OU	hor	Home 500 Resider		er (Specil	(v)	
o uc	After fune		27. Menner of Death Death Pending					28d. Describe how			,,		
18	Attending or death. actor: Afte by the fune	ICB	2 Accident Investigation 3 Suicide 6 Could not be determined elemined and suicide 128e. Place of Injury - At home, farm, street, factory, office							eet and Numb	er or Run	al Route Number.	_
Ö	affer din b	27. Menner of Death Carte Deat											
		edical		vatcten: To the best of my kno liner: On the basis of examina and manner stated.									
	rithin Fo th	ž -	29b. Signature and title of certifier			2	6	se number		d. Date signe	d (Month,	Day, Year)	_
			1 Chandel	Charle Mp	n	1PH	DI	17412		3/8	199		
	2		30. Name and address of person who c	completed cause of death (Item	n 23a) (Type, Print)					/ 1	/	
p			SHARON DLF	tosit 232	3	URLEA	ms.	St. B	ALTO, MI	0 21	224	-	
	State Registra	5	31. Date filed (Month, Day, Year) MAR () Q 1999	Registrer's Signa	ture	1					,		



State of Maryland	/ Department	of Health a	and Mental	Hygiene	(
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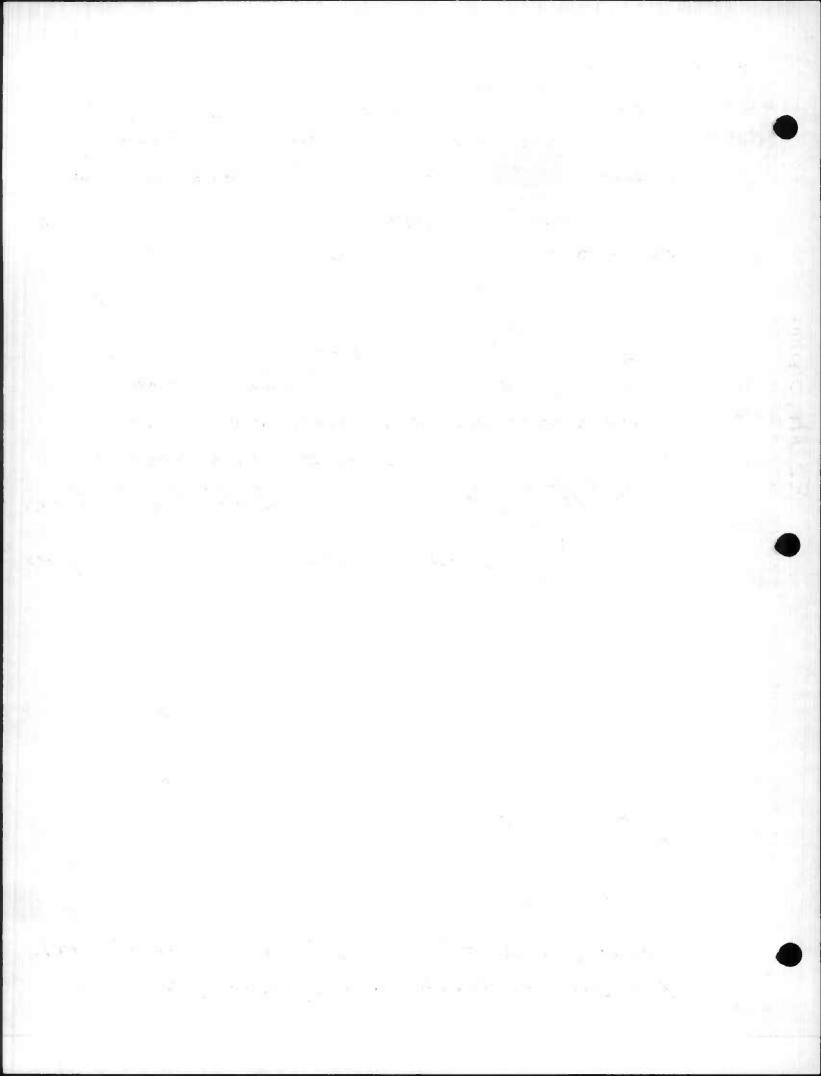
Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH MARCH 7, THURMAN DARR W. 3:45PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** ST. AGNES HOSPITAL BALTIMORE If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 10M 20 F 226-09-9404 78 Yrs. Director JULY 8, 1920 VIRGINIA Usuel Residence of Decedent 10a State 10c. City, Town or Location mant be notified at 10d. Inside City Limits Director MD BALTIMORE 1 ☐ Yes 2 No CATONSVILLE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2221 PLEASANT DRIVE 21228 U.S.A. Funeral death | 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Peges 1 end 2 should be filed within 72 hours after.
Department of Heelth and Mental Hyglene.
Important: If Itam 27 is marked other than "natural", or ites
any injury or other traumaths are and injury or other traumaths are and injury or other traumaths are and injury or other traumaths are and injury or other traumaths are and injury or other traumaths are and injury or other traumaths are and injury or other traumaths are and injury or other traumaths are also injury or other traumaths. No 14 Yes 2 No 14 Yes, Give Year or Detes: WWII 1 Never Married 2 Married 3 Widowed 4 Divorced altimore, Maryland 21215-0020 1 ☐ Yes 2☐ No Specify: à Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SPECIAL AGENT ATF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be LLOYD RAYMOND DARR CORA ALICE (EDDY) 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 14771 JUSTIFIABLE CT WOODBINE, MD 21797 19e. Informent's Name/Reletionship (Type, Print) DIANA CULLUM (DAUGHTER) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/11/99 WINCHESTER, VA. HEBRON CEMETERY 22. Name and Address of Fecility WITZKE FUNERAL HOMES, INC. e of Funeral Service Coense 1630 EDMONDSON AVE CATONSVILLE, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last P.O. Box 68760. granary Physician/Medical Due to (or as a cons Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown ate has been signed by page 2 should be detac Vaccular Occlusive Visease Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy Mellions Pulmonary Pizcase 105 morie 1 Yes 22 No 1 ☐ Yes 2 ☐ No. of Vital or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To this 27. Manner of Death 28c. Injury et Work? 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division After 1 Maturet 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifler pletaly (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 1120 N. Rolling Rd Catmobile MD Z1228 J.W. Code IV MID 31. Date filed (Month, Day, Year) 32. Registrer's Signature State MAR 9 Registrar



State of Maryland / Department of Health and Mental Hygienen

Item 9 Per FH Film G769 3-9-99 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** Month 2:10AM SHAHIN EZZATI /Medical 4b. City, Town, or Location of Death 08 1999 4a. Fecility Nema (If not institution, give street and number) 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year if Undar 24 Hrs. 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) Iran **Funeral** Deys Hours 1□ M 1 F 52 Yrs. Director 216-53-2666 JUNE 9, 1946 MARYLAND Usual Rasidance of Decedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? ò 2711 SUPERIOR AVE. 21234 Items 23a U.S.A. Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian, Black, Whita, atc. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or hear any injury or other trearments access 1 Navar Married 2 Married 1 ☐ Yes 🏋 No If Yas, Give 1 ☐ Yas 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) HOMEMAKER OWN HOME 12 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be MOUSA **NEMAN ASHRAF** DARVISH 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MR. DJALAL EZZATI / HUSBAND 39 ROBIN RIDGE CT., BALTIMORE, MD 21234 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1X Buriai 2 ☐ Cramation 3 ☐ Removel from Stata ROSEDALE, MD 4 Donation 5 Other (Spacify) BETH JACOB ANSHE VESHEAR 3/8/99 21. Signatura of Junaral San 22. Nama and Addrass of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Batween Onset and Death **Physician** /Medical immadleta Cause (Finel disaasa or condition rasulting in death) Examiner Due to (or es e consequance of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially ilst conditions, if any, leeding to Immadiata ceusa. Enter Undarfying Cause (Diseasa or Injury that initiated avants rasulting in daeth) Lest Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Dua to (or es e consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dtd tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ģ 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to completion of ceuse of death? Completed 2. No 1 Yas 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was cesa rafarred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Depatiant Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Dascribe how Injury occurred 28b. Tima of 28c. tnjury at Work? 1 Natural 2 Accidant 5 Pending 1 Yas 2 No Invastigation 6 Could not be determined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 29a. Certifier Medical 1 🕊 Cartifying Phystctan: To tha best of my knowledga, daath occurred et tha tima, data and place, end due to the ceusa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stated. 29b. Signature and title of certifian 29c. Licansa number 29d. Data signad (Month, Dey, Year) 052810 March 8, 1999 ted cause of daeth (Item 23e) (Typa, Print) Charles St, Baltimare, MD 21204 2. Registrar's Signetura State Registrar



State of Maryland / Department of Health and Mental Hygiene

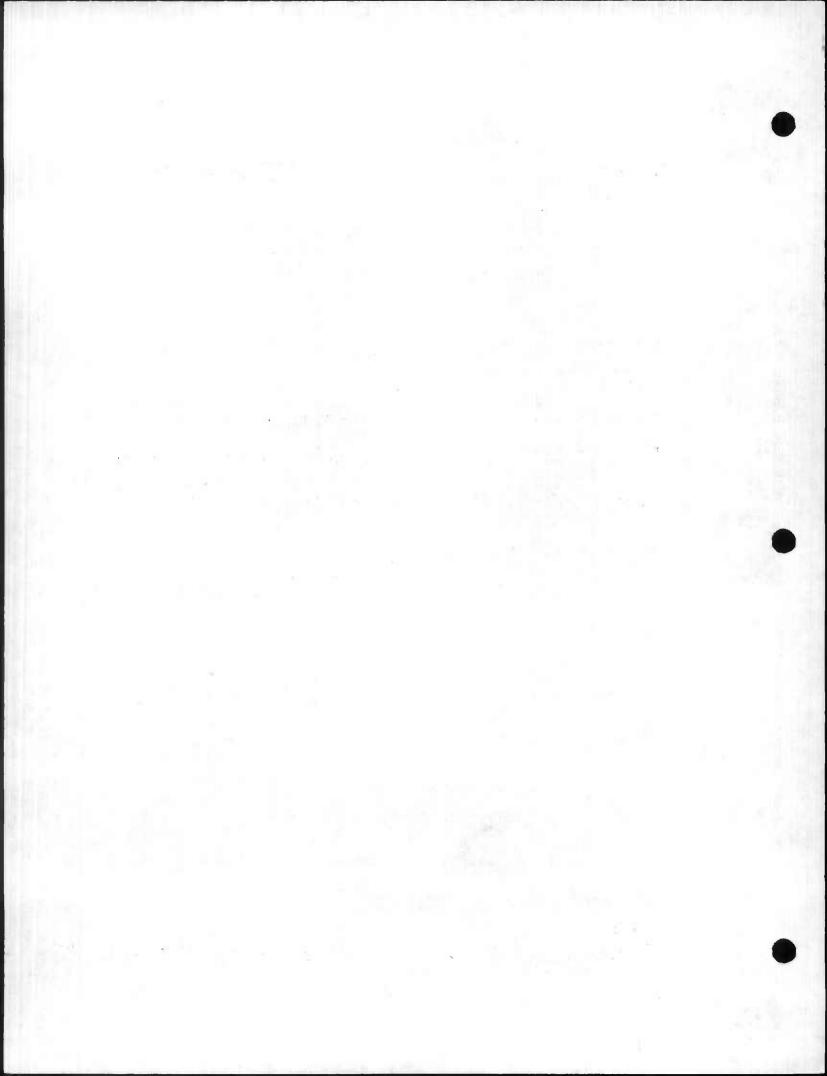
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month LILLIAN EPSTEIN MARCH 4, 1999 10:41 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days 1 M 2 F Hours Yrs 213-48-2071 101 FEB.4, 1898 Director MD Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or itema 23s or 28s-f show traumatic avant, the Madical Examinar must be notified at MD BALTIMORE BALTIMORE Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4204 OLD MILFORD MILL ROAD 21208 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (Z)No if Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed withir Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic avant, the Man Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ISRAEL SCHWARTZMAN SARAH BROWN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GILBERT EPSTEIN / SON 14 POMONA SOUTH #4 - BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XX urial 2 Cremation 3 Removal from State HEBREW FRIENDSHIP CEMETERY 3/7/99 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 e, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical sudde Examiner Examiner physicien end the burief-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760 Physician/Medical Due to (or as a consequence of) 80 0 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by a should be detact 1 Yes 20 No 3 Probably 4 Unknown Records, g 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy page 2 hes 1 ☐ Yes 2D No 1 ☐ Yes 2 ☐ No certificate Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2EXNO 1 Inpatient 2 ☐ ER/Outpatient 3 DOA this funeral (27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After **E**Natural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide 17 Ortifying Physician: To the best of my Innowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely 29b. Signature and life of certifie 29c. License number 29d. Date signed (Month, Day, Year) ho who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AGNES BEATRICE FINCH 8:40 pm 28 1999 EbUAR 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death GENESIS CARE -RANDALLSTOWN RANDALLSTOWN BALTIMORE If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign
Country) 1□M 2**F**F Days Months Yrs. 220 01 0301A OCT.20,1901 MARYLAND Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD. BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. OF A. 9109 LIBERTY ROAD 21133 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced BLACK 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) FACTORY WORKER N/A N/A CANNING FACTORY 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) RICHARD DYSON LOUISA WILLIAMS 19a. tnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD DYSON (NEPHEW) 3603 BLACKSTONE RD. RANDALLSTOWN, MD. 21133 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Baltimore, Md Mt. Zion Cemetery 21. Signeture of Funeral Service License 22 Name and Address of Facility LEWIS T. GWYNN 4517 PARK HEIGI FUNERAL HOME 21215-6393 PARK HEIGHTS AVENUE BALTO., MD. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on a line. Intervel Between Onset end Death Immediete Ceuse (Final 10501 YEars disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Carcinoma 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred termedical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner that the death certificete be executed physician and the bunal-trans attending ph for use as ti signed by the a this funeral After

ils certificata has b director, page 2 s Attending Physician: death.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

7 is marked other than "natural", or items 23a or traumatic event, the Madical Examinations

Directo

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Completed

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Peges 1 and 2 should be in nent of Health and Mental I

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Physician /Medical

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(Check only one)

29a. Certifier

Division of Vital Records, P.O. Box 68760, after death Director: A 24 hours after Funeral Dire letely filled in E To the I within 2.
To the I complet

State

Registrar

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and mention as elaborated.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

03/03/99

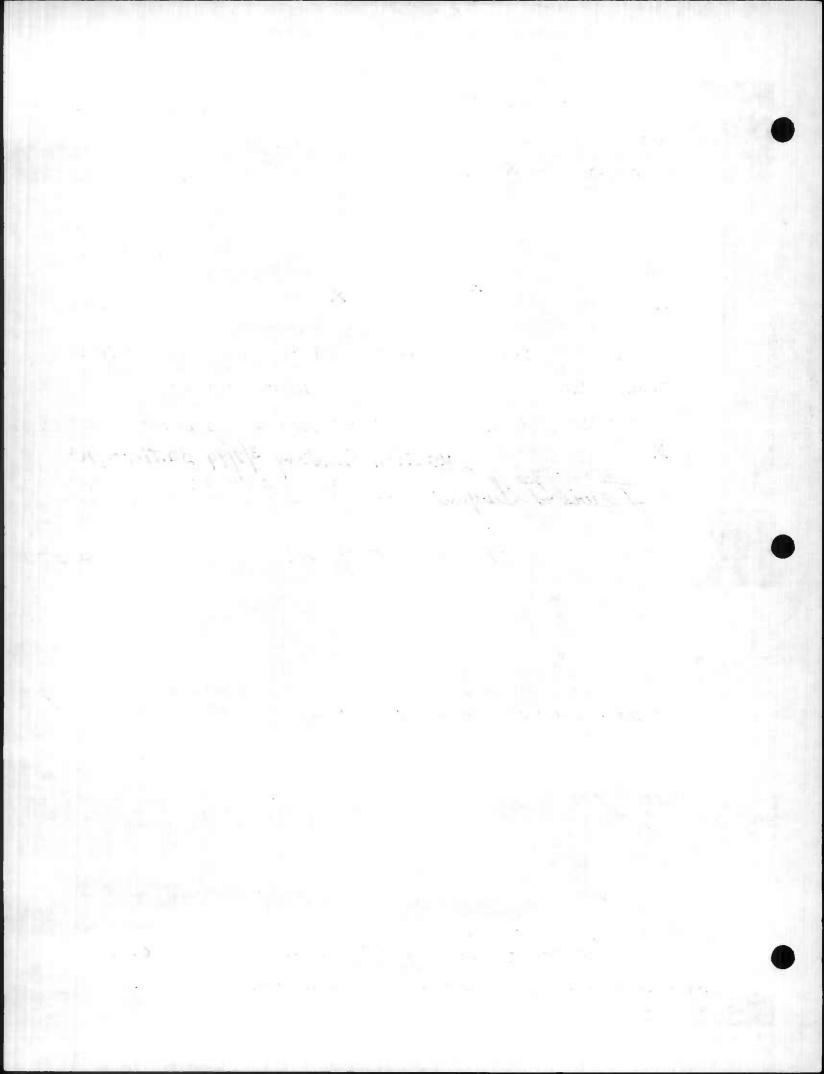
30. Name and address of person who completed cause of death (Item 234) (Type, Print)

M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133 Jerome H. Ginsberg, 31. Dete filed (Month, Dey, Year)

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32. Registrar's Signeture Doork

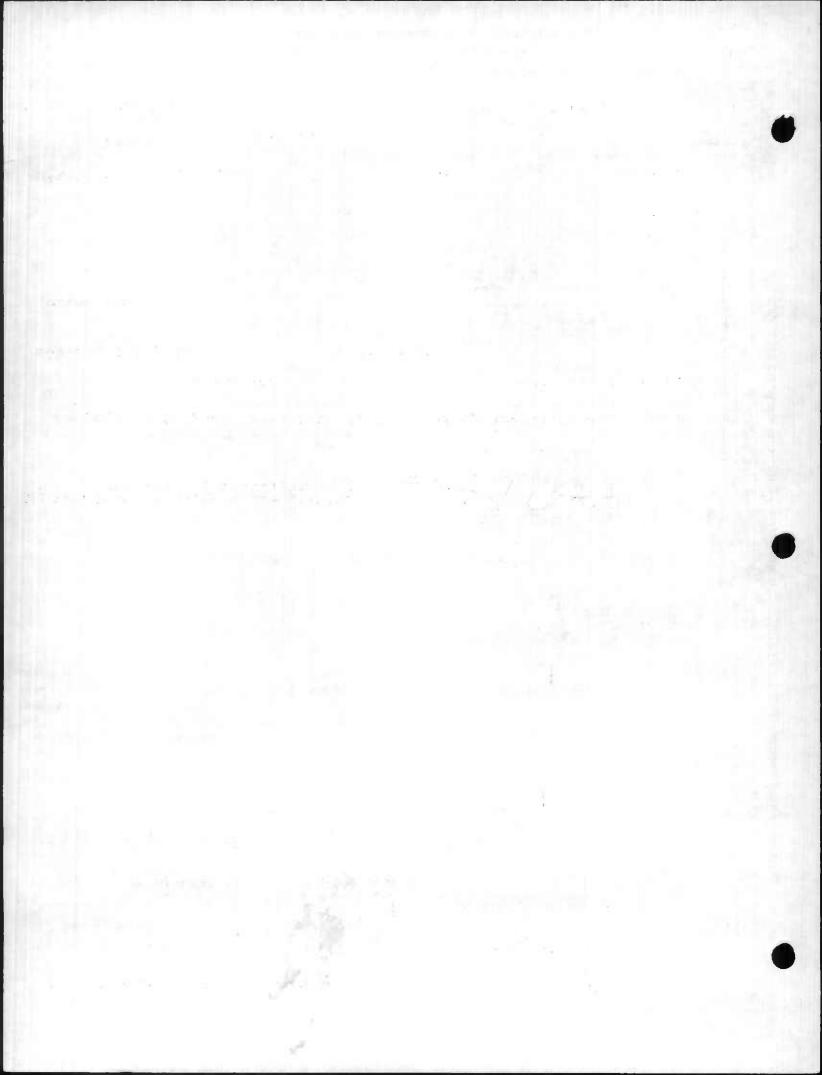


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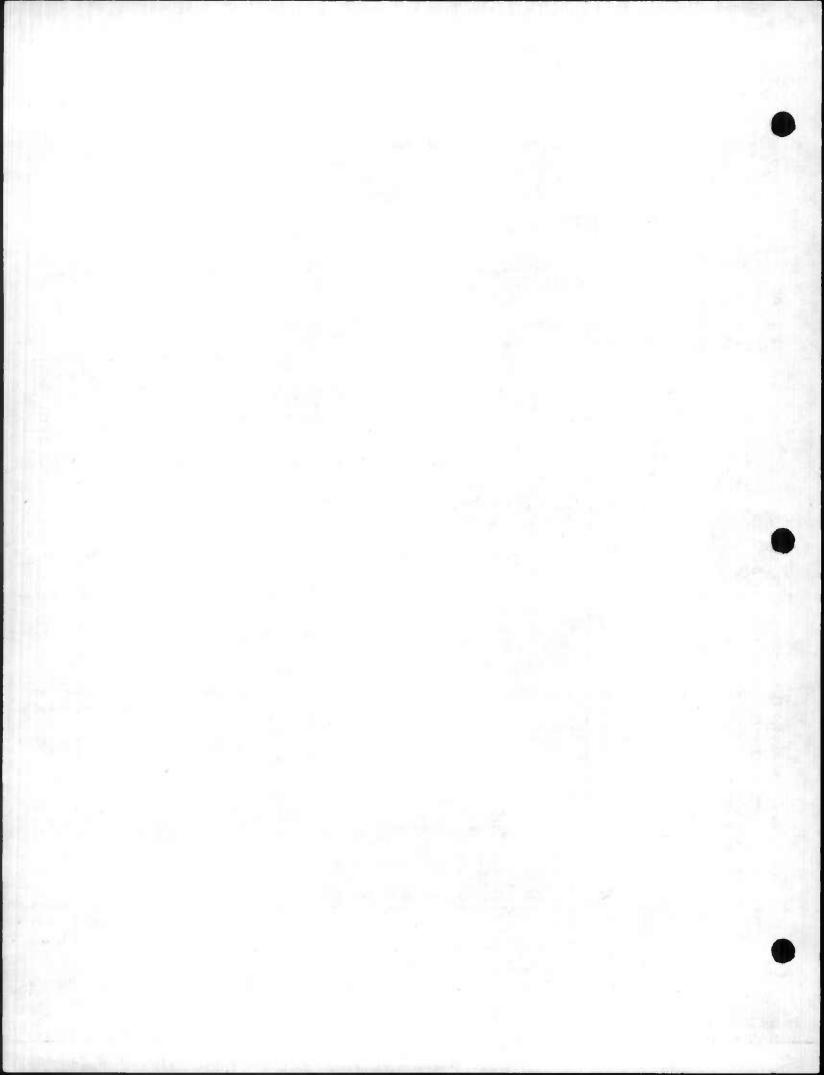
Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day WHITFIELD FOWLER MARCH 03,1999 13:50 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LOPKINS 6. Sex BAHMORE CITY
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day 7. Age (In yrs. last birthday) Johns If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1X M 2□ F Months 79 Director 241-26-4864 NC 11-22-19 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow XXYes 2 No Director MD 28a-t Baltimore must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or lisms 23s or 11 West 20th Street Apt.13R 21218 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? XIXYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. hours after 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: à X₩idowed 4 Divorced Black Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiere. Elementery/Secondary (0-12) College (1-4or 5+) 2nd Grade Laborer Dickerson & Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be armit. Pages 1 and 2 should be bepartment of Health and Mental mportant: If them 27 is marked of William Folwer Carrie Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Fowler 416 N. Bradford Street Baltimore, MD. 21224 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cem. 03-10-99 Owings Mills, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue luin 23a. Part1. Enter the disease of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daath **Physician** /Medical Immediata Causa (Final 30 years disease or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner attending physician and for use as the bunal-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 XYes 2 No 3 Probably 4 Unknown Records, p The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital oaptal or Attending Physician: hours after death. uneral Director: After this certifica by filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 24 hours Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatore and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 000 MARCH 03 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPITAL ZIDAR LOVNEC DAVID Toner 31. Date filed (Month, Day, Year) 32. Registrar's Signeture-State Registrar MAR 9



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month Voor 1:00 Am DOROTHY MIRIAM FIFER MAR 1999 4a. Fecility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Good Will Mennonite Nursing Home Grantsville Garrett If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) 1 M 2 KF Months Yrs 214-01-2241 Sept. 9, 1918 MD Usuel Rasidanca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Westminster 1 ☐ Yas 2 No 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 2622 Bird View Rd. 21157 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Detas: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - Amarican Indien, Bleck, White, etc. 11. Marital Stetus 1 Never Married 2 Married 1 Yes 2 No Specify 3 Nidowed 4 Divorced White 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Collega (1-4or 5+) Housewife Own Home 18. Mother's Neme (First, Middle, Maiden Sumema) Ruth Olivia Pick 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Son 2622 Bird View Rd., Westminster, MD 20b. Place of Disposition (Nema of cematary, crematory or other piece) 20c. Location - City or Town, Stete 3/12/99 Marriotsville, MD Crest Lawn Cemeterv

permit. Pages 1 and 2 should be filed within 72 hours after.
Department of Health and Mental Hygiene.
Important: if hem 27 is marked other than "natural", or iter any injury or other traumatic event

Physician

/Medical

Examiner

10a State

Director

Funeral

MD

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at

the Maryland

with

Saltimore, Maryland 21215-0020

Physician /Medical **Examiner**

esn ö page 2

physician and the burial-transit The law requires that the death certificete be executed Box 68760. Division of Vital Records, P.O. the a peen has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified

Examiner Be 2 Certification:

þ Completed 11 To Immadiate Ceuse (Finei disease or condition rasulting in deeth) Physician/Medical à

Completed

State Registrar

Elamentary/Secondery (0-12) 17. Fether's Neme (First, Middle, Last) Clevland Hammett 19a. informent's Neme/Raletionship (Type, Print) James C. Fifer 20e. Method of Disposition 1 Bunel 2 Cremation 3 Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funerel Sarvica Licensee, 22. Name end Address of Facility 11824 Reisterstown Rd. ene Eline Funeral Home Reisterstown, MD 23. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrasf, whock, or heart feilure. List only one cause on each line. Approximate interval Between Onsat and Death Kenorarcinoma - Stomach Due to (or es a consequence of): Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in deeth) Lest Dua to (or es e consaguence of): Dua to (or as e consequance of): Pert II. Other significent conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of daath? 24e. Wes an eutopsy 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? 26. Pleca of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetiant 3 DOA 28e. Date of injury (Month, Dey Year) 27. Manner of Death 28b Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, fectory, office building, etc. (Spacify) 4 Homicide 1 🗹 Certifying Phyeician: To the best of my knowledge, daeth occurred at the time, date end plece, end due to the causa(s) and mannar as stated. 29e. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature end title of certifier 29d. Dete signed (Month, Dey, Yeer)

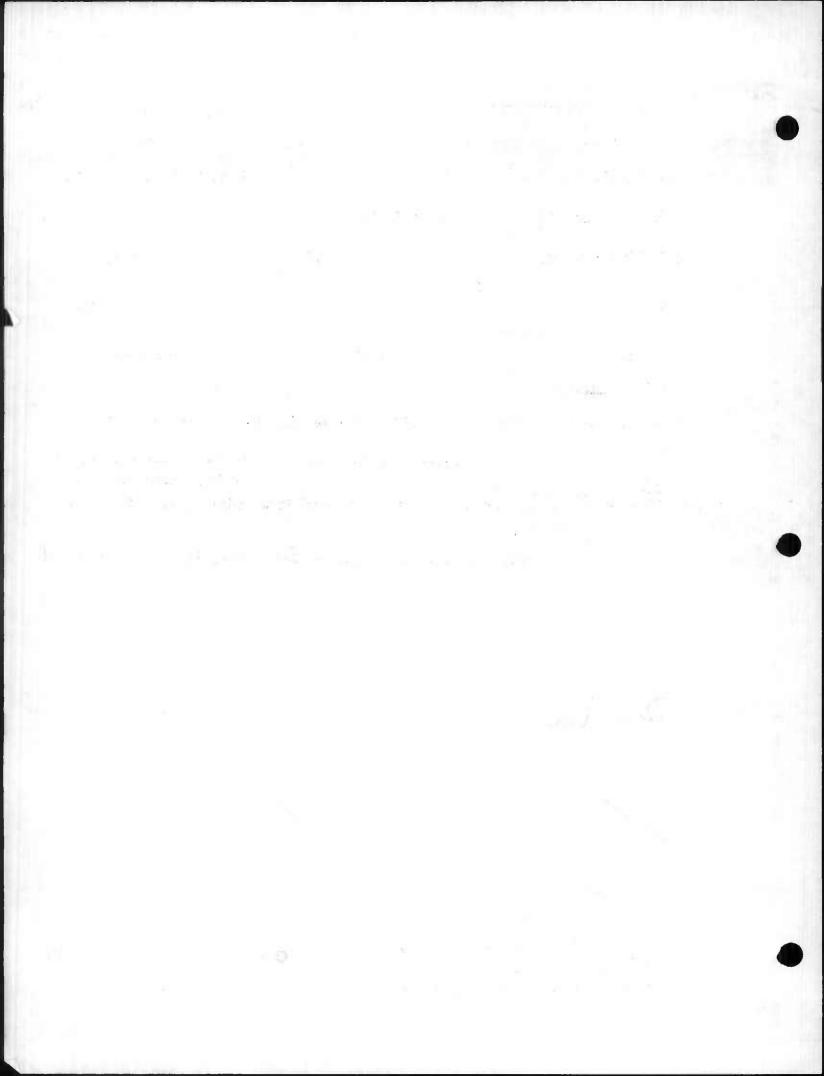
leted cause of death (Item 23e) (Type, Print) ddress of person who ed

Deitzel

riantsuille MD

31. Deteriled (Month, Day, Year)

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Am 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Frederick tol 03 05 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Westminste Genera C91101 Lount 05 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. | June 26, 1915 5. Social Security Number 9. Birthplace (State or Foreign Country) Balto. Md. & SOY 7. Age (In yrs. last birthday) Months M 2DF 83 Yrs. 215-03-5680 Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Md. Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 USA 107 Lampport Road Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian 1/XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Gulf Oil Co. Sales Person 12 Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles C. Folkert Mabel Whitney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Folkert (Daughter) 107 Lampport Road Reisterstown, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 3 Burial 2 Cremation 3 Removal from State 3/8/99 Finksburg, Md. 4 Donation 5 Other (Specify) Evergreen Memorial 21. Signature of Funeral Service Lightner 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Md. 23a Furth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allock, or heart failure. List only one cause on each line. m Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury et Work? Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, The law requires that the deam 0.0 of Vital Records, or Attending Physicien: funeral director, this Division i Director: Aft d in by the fur filled in by To the Hospital within 24 hours To the Funeral completely filled Hospital

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after a ment of Health and Mental Hygians.
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Department of Important: If any Injury or ange.

Physician /Medical

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Hygions. other than "natural", o ent, the Medical Exer

the Marylan

21215-0020

Baltimore, Maryland

State Registrar

30. Name and document of person who completed cause of death (Nem 23a) (Type, Print)

Grene & Hospital, 200 memorial A

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR n 9 1999

3 Suicide

4 Homicide

(Check only one)

Avenue 32. Registrar's Signature

mp

Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

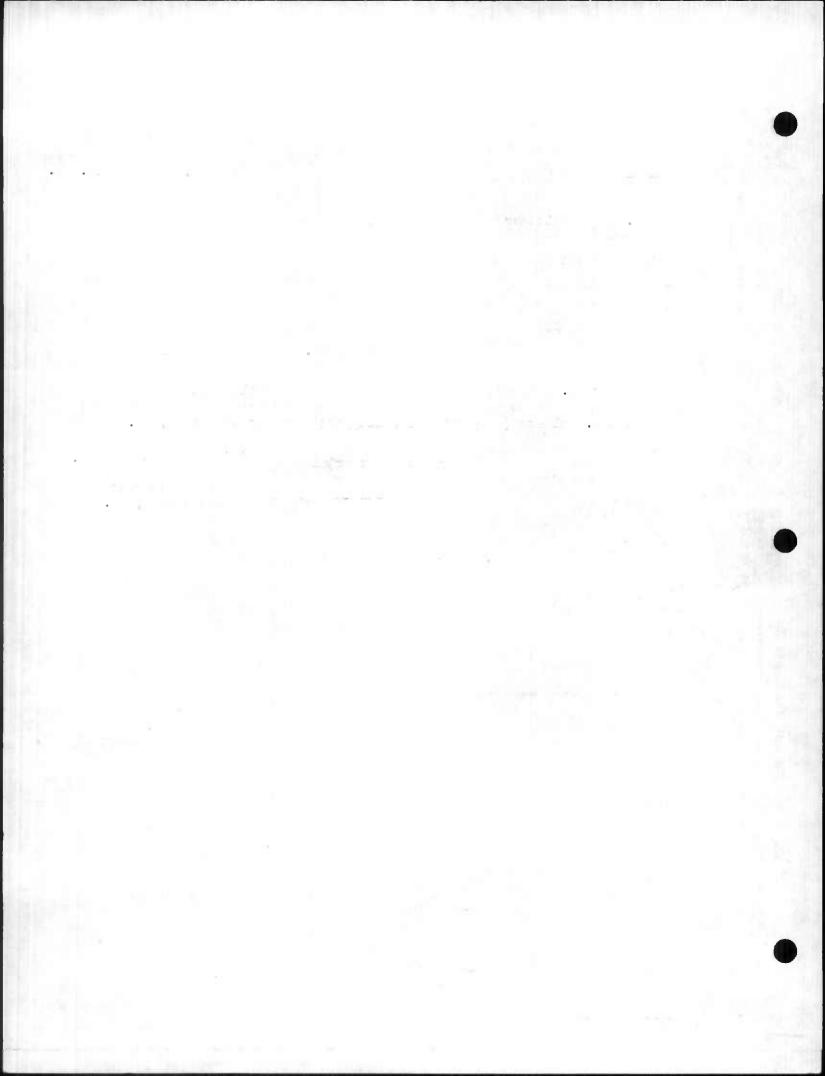
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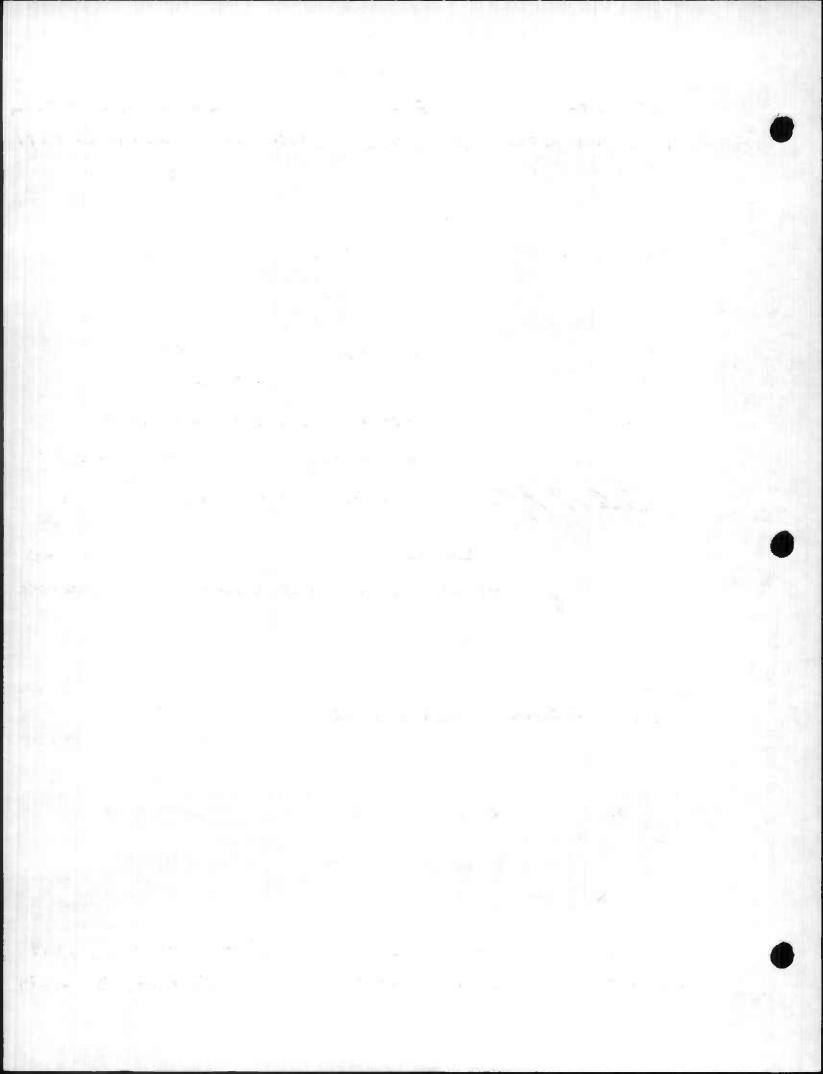
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State of Maryland / Department of Health and Mental Hygiene 9

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/Medical	Decedent's Name (First, Middla	, Last)					2.	Date of De Month	ath Day	Yaar	3. Time of Death	
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er	4a Facility Name (If not institution,					4b. City, To				nty of Death		
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by Funeral Director	11. Marital Status 1 □ Never Married 3 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? ad 1 ☐ Yes 2 ☑ N If Yas, Give Yaar or Dates:		1	Vas Decedent of Yes, specify Cu ☐ Yes 2⊠ No	ban, Mexican	gin? (Specify , Puarto Ric	Yes or No an, atc.)	В	laca - Americ Black, Whita, city: Whit	atc.	
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nple	Elamentary/Secondary (0-12)	College (1-4or 5		life. L	OO NOT use retir	ed)			TT - '	4.1		
Co	8		В	Boile	r Maker	1			Hospi			
To Be	17. Father's Name (First, Middle, Last) Edward Fox						,	ne (First, Middle, Maiden Sumema) n Bounce				
_	19a. informant's Name/Ralationsh	lp (Type, Print)	1	9b. Mailir	g Address (Street	et end Numbe	er or Rural R	oute Numb	er, City or Tox	vn, Stete, Zip	Code)	
	Shirley Fox			5625	Greenh:	ill Ba	ltimor	e, Ma	ryland	21206	5	
	20a. Method of Disposition 1 □ Burlai 2 □ Cramation		ceme	tery, cren	Disposition (Nema of y, cremetory or other place) ood Cemetery)/99	20c. Location - City of		or Town, State Maryland	
	4 Donation 5 Other (Sp 21 Signature of Funeral Service L		Talk								laryrand	_
	22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland										21206	
	23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that caused	the death. D						-		Approximate Interval Between	
	SHOCK, OF HEART FAILURE. LIST C	why the cause on each in	ia.							1	Onset and Death	4
	Immediate Cause (Final disease or condition	. 5	EP SI	2							4 DAYS	
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	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С										
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8	resulting in death) Last									i		
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	Part ii. Other significant condition		ıt not rasultinç	g in tha u	ndarlying causa ç	jivan in Part i			-		o the cause of death?	
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To Be Completed by Physician	Part II. Other significant condition		MLT		OKME	26. Place	of Death (C	1 □ 24a. Was perfo	an autopsymmed?	24b. W av co of	fere autopsy findings railabla prior to mpletion of cause daath?	7
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Item#17 per Inf G769 3/12/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARION Soumty of Death 8:256 March /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner 17 More
18 Under 24 Hrs. 8. Date of Birth
(Month, Day, Honlans ohns N/A to SAIG 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 1 □ M 2 X F Months Days 217-22-7298 72 Yrs. Jan. 6,1927 Director Maryland Usual Residence of Deceden 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits tem 27 is marked other than "naturel", or itema 23s or 28s-f show other traumatic event, the Medical Examinar maint on notified at 1 Yes 2 □ No Maryland Bel Air Harkord Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 405 Daniel Court 21014 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married e filed within 72 hours after al Hygiene.
Other than "naturel", or i Saitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White g 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Floor Covering Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Distribution 12th Grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If fem 27 is marked othe eny injury or other traumatic event, pates. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Salvatore LoPresti Carmela Butta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Danielle L. Hartley (daughter) 1562 Bentley Circle, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of carnetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem'l Gari 3/8/99 4 ☐ Donation 5 ☐ Other (Specify) Timonium. Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) hours Examiner Examiner hour burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician s the burial Box 68760. Physician/Medical Due to (or as a cons 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No SProbably 4 Unknown 4ems à 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner/ 1⊠Yes 2□ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 tnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 24 hours after deeth. 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examiner and manner stated. (Check only one) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000

State Registrar

DHMH 16 Rev 6/95

BALTIMORE, MD 21287

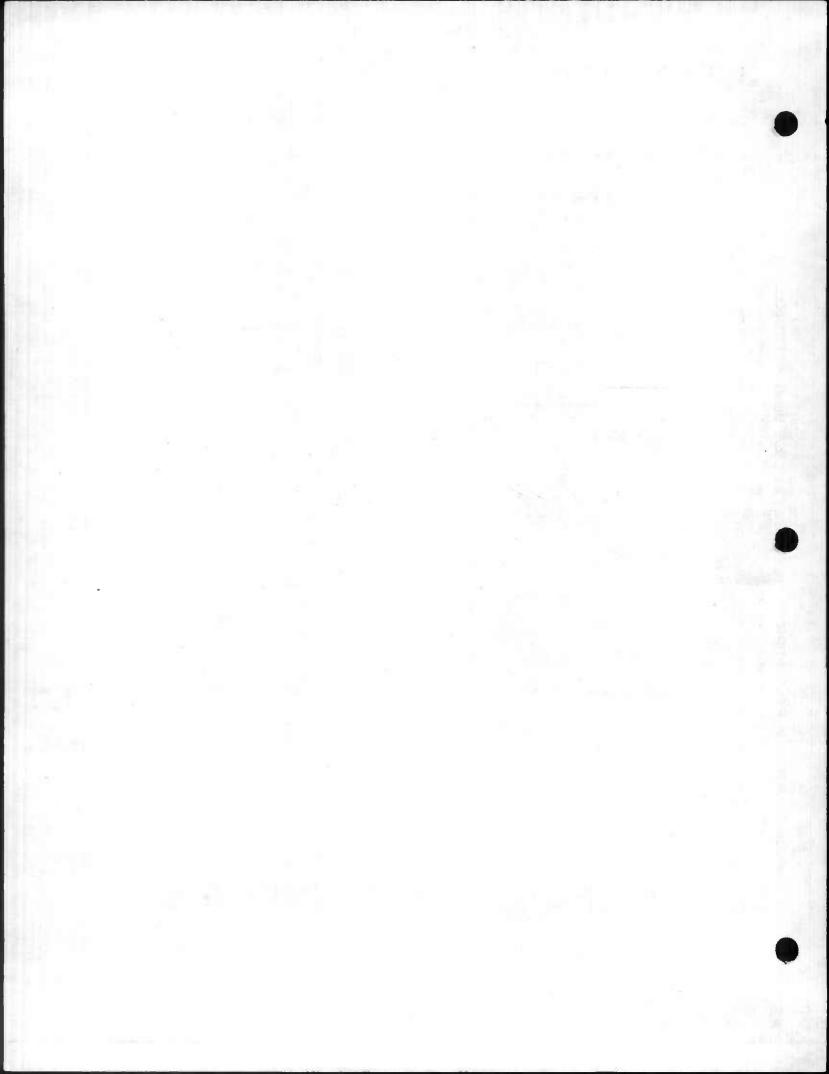
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 NORTH WOLFE ST

32. Registrar's Signature

SUNIL SINGHAL MD.

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

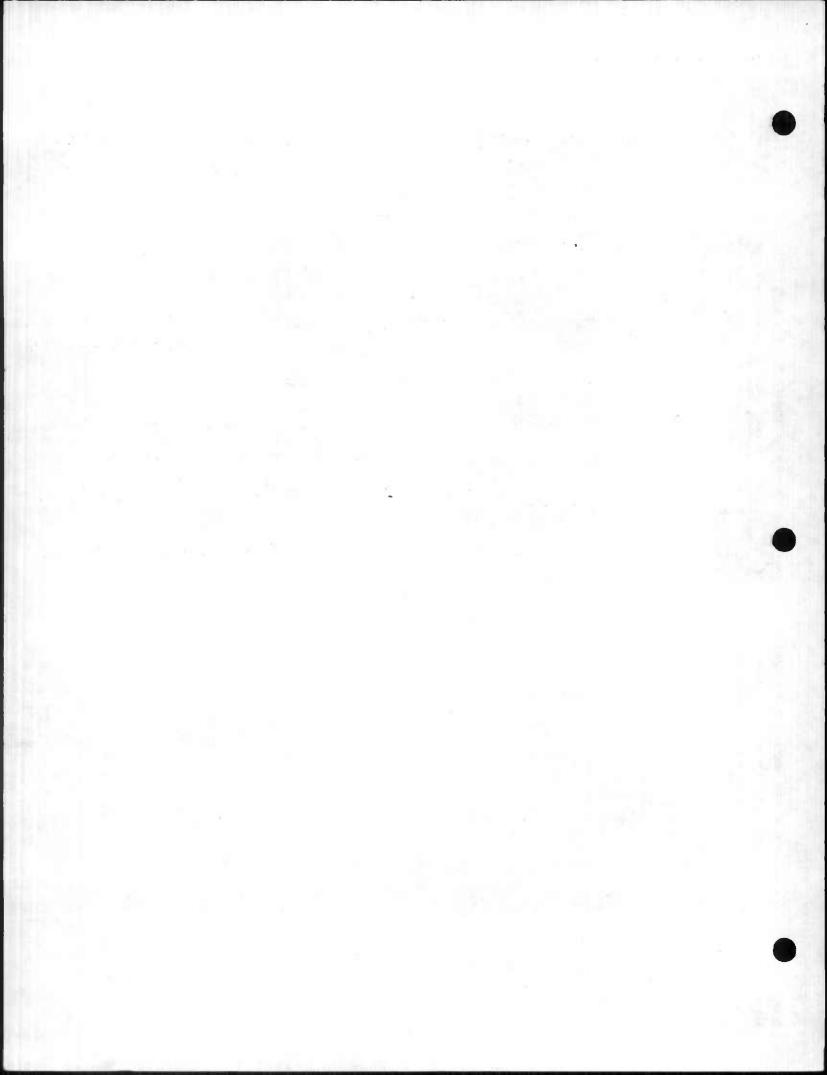
State of Maryland / Department of Health and Mental Hygiene 9 9 7 3 9 5

Item 19b Per FH FilmG769 3-9-99 rja Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day 1999 MARCH 4, **Physician** REGINA GIRSHIN 2:33 AM /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner 130 SLADE AVENUE #303 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF 215-10-3556 81 MD Director Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yas 2 No Director MD BALTIMORE BALTIMORE 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code natural, or harm 23a or 130 SLADE AVENUE #303 21208 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Nevar Married 2 Married 1 ☐ Yes 2 ☒ No If Yas, Giva Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE p 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Bustnass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) EDDIE'S SUPERMARKET BOOKKEEPER permit. Pages 1 and 2 should be tile.
Department of Health and Mental Hy,
important: if Nem 27 is marked other any Injury or other 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be BENJAMIN **GORDON** BERGER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Knollcrest Road 12402 KNOLLCRESTROAD - REISTERSTOWN, MD 21136 JERRY GORDON / NEPHEW 20b. Place of Disposition (Nama of cematary, cramatory or other place) HEBREW 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Removal from Stata MOSES MONTEFIORE WOODMOOR 3/5/99 BALTIMORE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funaral Sarvice Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** ON GEST JUR HEART FATLUER /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner bunal-transit and Sequentially list conditions, if any, taading to immediata causa. Entar Underlying Cause (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): physician a Box 68760. that the death certificate be Physician/Medical Due to (or as a consequence of): attending p 23b. Did tobacco use contribute to the cause of death? P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown bengis leb ed b Records, by 24b. Wara autopsy findings available prior to should Completed 24a. Was an autopsy completion of causa of death? 1 Yas 20 No 1 Tyes 2 No certificate Division of Vital I or Attending Physician: after death. 25. Was casa referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Othar: 4 Nursing Homa 5 Assidence 6 Othar (Specify) Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After thi funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accidant Director: 3 Suicida 6 Could not be ne Hospital or Attendent 24 hours after de he Funeral Directo pletely filled in by the 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) within 2. 29b. Signatura and title of pridition 29c. License number 29d. Data signed (Month, Day, Year) 30-Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) RD STE 300 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar



Grigory Semenovich Gurevich

State of Maryland / Department of Health and Mental Hygiene 9 7396

31						0	ertifica	te of	Death		Reg. No.		1000
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	/ledical aminer	4e Fecility Neme	(If not institution, give	street end numbe	r)				4b. City, Town, o	r Location of Deet			0.40 A.PI.
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ath with th	oner must be notified Funeral Director	10e. Street end Number 6210 BREEZEWOOD COURT APT. 303									RUSSI		ntry?
2-0020 72 hours after death with the Maryland natural; or items 23s or 28s-f show	by		rried 2 Married 4 Divorced	12. Wes Deceder Armed Forces 1 Yes 2 If Yes, Give 2 Year or Dafes	? No	,S.	13. Wes Dece if Yes, sp 1 \(\superscript{Yes}\)	ecity Cubi	lispenic Origin? en, Mexican, Pud Specify:	(Specify Yes or No erto Rican, etc.)	Blee	e - Americ ck, White, WHITE	etc.
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Physic /Med Exami	ical iner	23a. Pert1. Enter shock, or he Immediate Cause disease or condition resulting in deeth)	ion	olicetions thet caus one ceuse on each	Han	911			ng, such es card	iec or respiretory e	rrest,		Approximate Intervel Between Onset end Deeth
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= - 6										18	Yes 2□No	1[Fres 2□No
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2 24 5	Certifi	4 🗌 Homicide	determined	bullding,	etc. (Specif	(y)	home			Green bell	, ru	10 Bre	ejewood Ct # 303
To the Hospital within 24 hours a To the Funeral C	pletely fi	29e. Certifier (Check only one)		yelcien: To the bes niner: On the basis end menner:	of examine								
To the To the	X	29b. Signature en	d title of certifier	201			2	oc. Licens	e number		29d. Date signe	d (Month,	Dey, Year)

State Registrar

30. Name end address of person

DennisJ , mp 31. Dete filed (Month, Day, Year) MAR 9

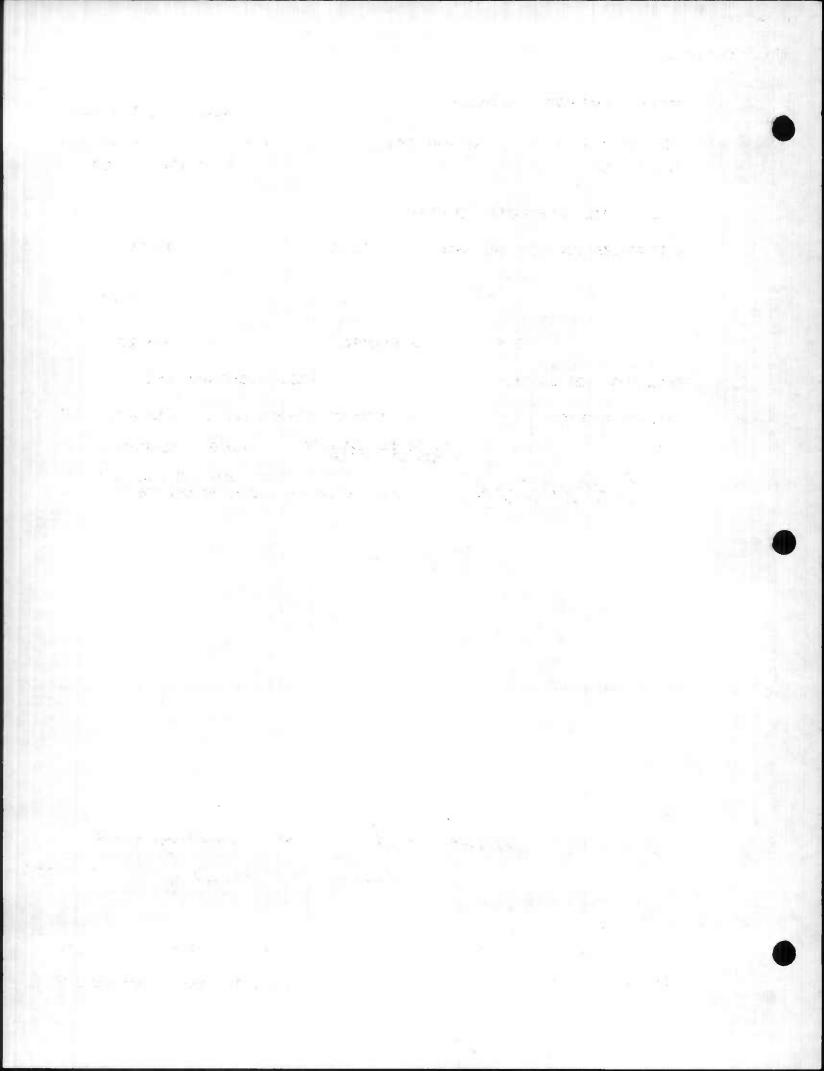
32. Registrer's Signeture

pleted cause of deeth (Ilem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

February 13, 1999

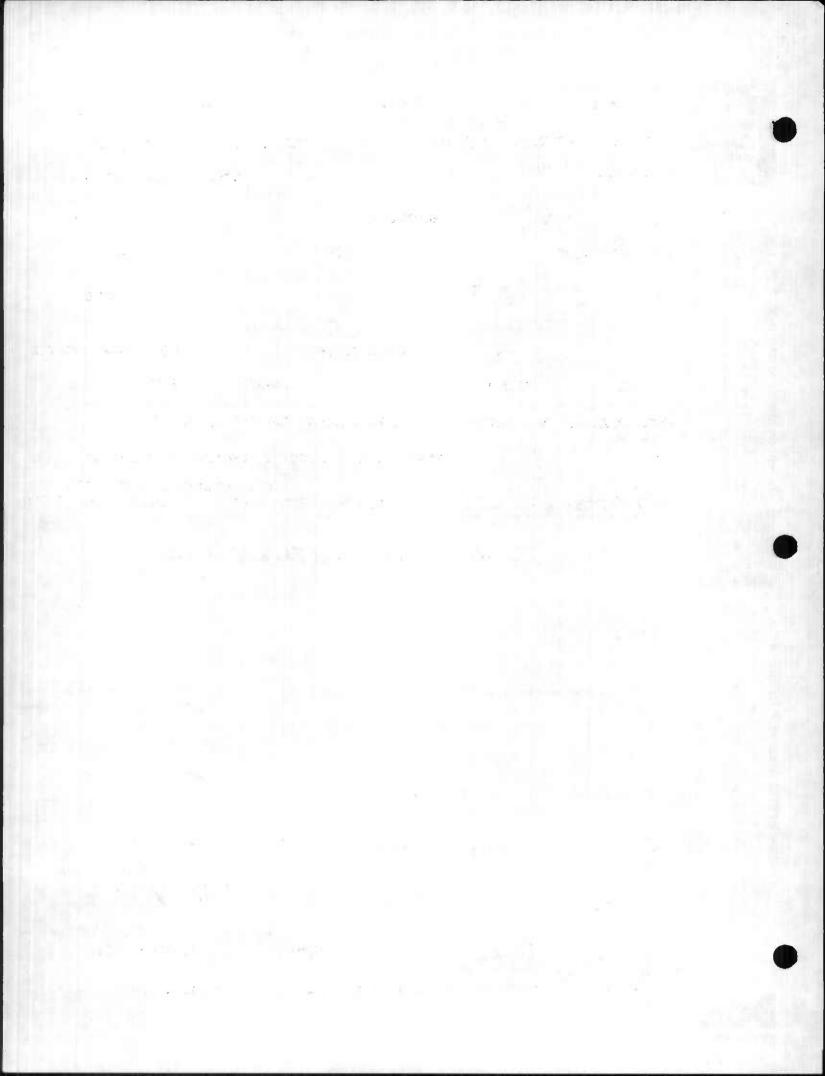


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State of Maryland / Department of Health and Mental Hygiene O

12:	58-031				State 0	i waiyiai				Death		Reg. No.	U	1391			
		_	Decedent's Name (First, Middle, Last)							2. Date of De Month	ath		3. Time of Death				
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	/Medical Examiner	4.0	Fecility Name (If n	ot institution, giv	e street and nu	mber)				4b. City, Town, or	MARCH Location of Deet		_	1223 FM			
	LAdminer	١.	SHADY GR	OVE ADV	ENTIST	HOSPITA	T.			ROCKVII							
ŀ	Funeral	5.	Social Security Nur			7. Age (In yrs.			er 1 Year	If Under 24 Hrs				lace (Stete or Foreign try)			
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lai	should be filed within of Mental Hygiene. marked other than matic event, tre M		ELI		GORDON	1				SARA	H	BERMA	N				
Maryland			9a. Informant's Nam	e/Relationship (Type, Print)		19b. Maili	ng Addre	ss (Street	and Number or R	u <i>ral Rou</i> te Numb	er, City or Town	State, Zip	Code)			
Σ	and 2 seath ar n 27 is		MRS. SAR	AH GORDO	ON / MO	CHER	2429	HUN'	r DRI	VE, BALT	IMORE, N	4D 21209)				
re,	es 1 and of Health f item 27 r other tr	20	a. Method of Dispos	sition		20b. I	Ptace of Disponentery, cre-	osition (N	ame of	na)	Date	20c. Location	City or To	wn, State			
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	D 1 -1-1-1		shock, or heart	failure. List only	one cause on e	ach line.			,					Intervel Between Onset and Deeth			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Deeth Month **Physician** Grinman Khalya 1999 march 120AM 7th /Medical 4a. Facility Nama (If not institution, give street end number, 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE 5. Social Security Number If Undar 1 Yaar | if Undar 24 Hrs. 6 Sax 7. Aga (In vrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Deys Hours 1 M 2 F Yrs. Director 216-37-0724 91 JAN. 1, 1908 UKRAINE Usual Rasidanca of Decedant 10a Stata 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2√ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7920 SCOTTS LEVEL ROAD 21208 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva A Yaar or Dates: Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify. py Specify: WHITE 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) HOMEMAKER OWN HOME 8 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middla, Maidan Surneme) Be **NACHMAN** MELAMED **BRUCHA** (UNKNOWN) 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 6884 MILBROOK PARK DR, #1C, BALTIMORE, MD 21215 MRS. RAKHIL GRINMAN / DAU. 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from State OWINGS MILLS AND GARRISON FOREST RD. 3/8/1999 HAR SINAI CONGREGATION 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signati 22. Nama and Addrass of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, 21208 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or hagit failure. List only one cause on each line. Approximata Intarval Batween Onset and Deeth **Physician** Immediata Cause (Final diseasa or condition resulting in daeth) Examiner Sequantielly list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated events resulting in daath) Last Physician/Medical Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 XYes 2□ No 3 Probably 4 Unknown by Completed 24a. Was en eutopsy performed? Wara autopsy findings available prior to completion of causa of deeth? 1 🗆 Yas 1 ☐ Yas 2 ☐ No Be 25. Was casa referred to medical 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 10 1 Yas 2 🗆 💢 1 npatiant 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Mannar of Deeth 28b. Time of 28d. Describe how Injury occurred Medical Certification: 5 Pending invastigation Natural Injury 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stete) 4 Homicida

be exec Box 68760. The law requires that the death P.O. P Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

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29b. Signeture end title of cartifier

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ettending physician

Baltimore, Maryland 21215-0020

r than "natural", or items 23s or 28s-f show the Medical Examiner must be noutled at

State Registrar

30. Nema and address of person who completed ceuse of death (Item 23e) (Type, Print) OKTH WE 31. Data filed (Monti MAR 9 Year) 32. Registrar's Signatura

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

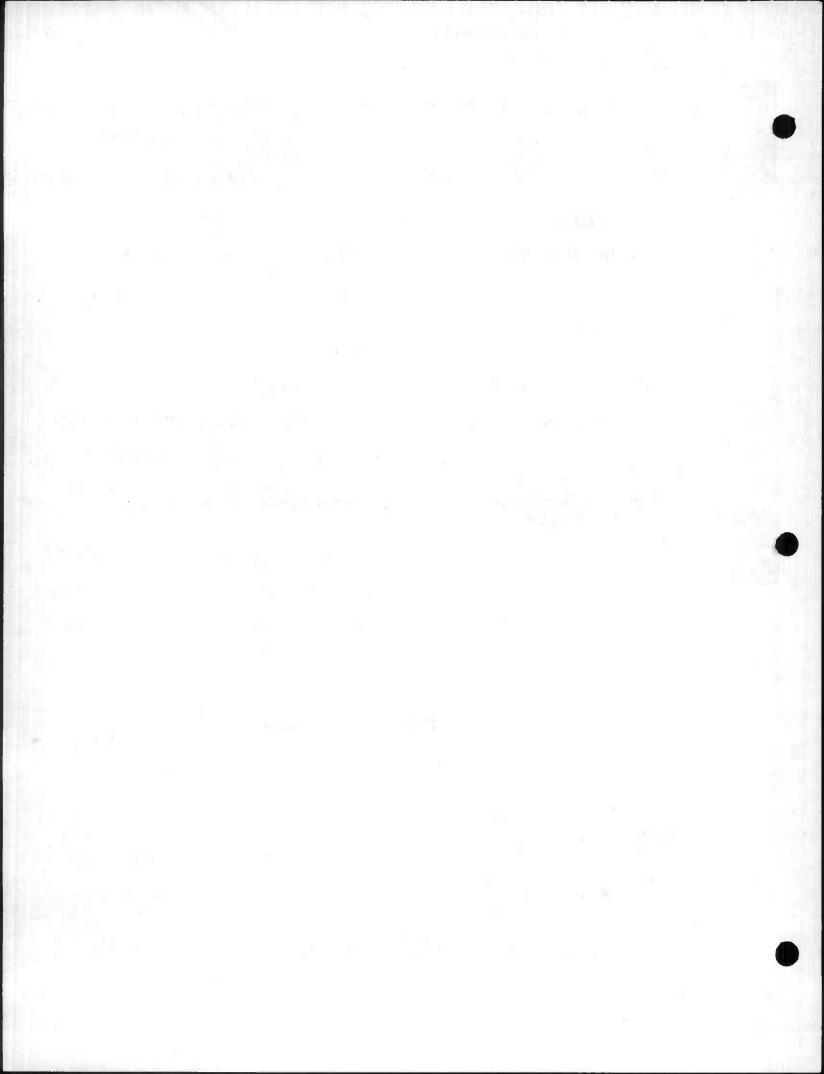
29c. Licansa number

29d. Data signed (Month, Day, Year)

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Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No: 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year 04 **Physician** ELIZABETH C. March 199 **GUTKOSKA** /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not Institution, give street end number) 4c. County of Death Examiner BALTIMORE
If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year) BON SECOUR HOSPITAL If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Days Yrs. 85 Director 225-05-4994 SEPT 18, 1913 MISSISSIPPI Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23a or 28a-f show 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2117 DENNISON STREET 21216 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American indien. 11. Marital Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No Specify: à 3 Widowed 4 Divorced WHITE Completed 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) TELEPHONE OPERATOR 12 CIVIL SERVICE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be to Depentment of Health and Mental Important: If item 27 is marked or any Injury or other traumatic eve (UNKNOWN) **GUTKOSKA** MARY HARPER 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) SR. M. FERDINAND , R.S.M. 6806 BELLONA AVE. BALTIMORE, MARYLAND 21212 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 3-7-99 BALTIMORE, MARYLAND LOUDON PARK CEMETERY 21. Signature of Funerel Servica Licansee 22. Name and Address of Facility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. You 736 EDMONDSON AVENUE, BALTIMORE, MD 21228 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical immediate Cause (Final Theumonia disease or condition resulting in death) Examiner Examiner Dementia physicien end the burial-transit Sequentially list conditions, it any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Physician/Medical Due to (or as a consequence of): Se attanding for usa as Part fl. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the a 1 Yes 2 No 3 Probably 4 Unknown Decubitus Uleers by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was en europsy Completed performed? ils certificate her 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complataly filled in by the funeral director; to 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Department 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of fnjury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide 1 V Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the ceuse(s) and manner stated. 29e. Certifier Medicai 29b. Signeture end fitte of certifier 29d. Date signed (Month, Dey, Year) 29c. License number

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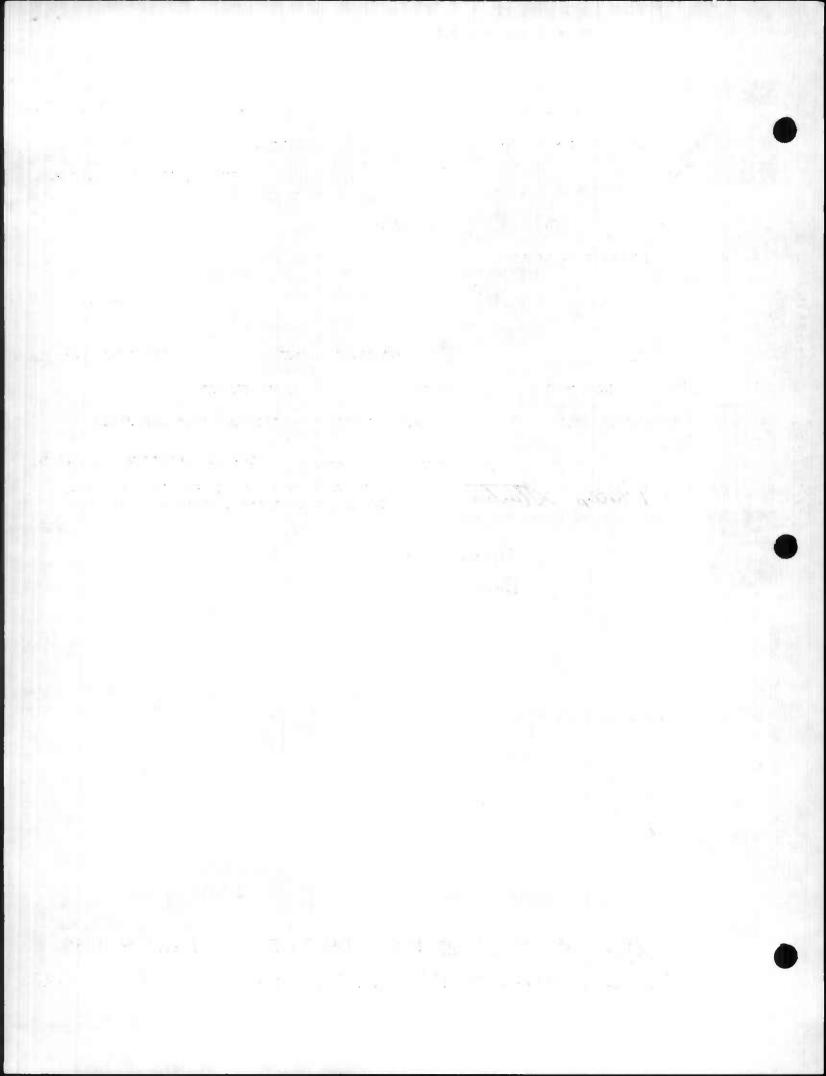
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Wish M M.D.

2000 West Baltimore St.

21223



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth **Physician** Robert D. Gordon March 1999 6, 18:09 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington Adventist Hospital Park Takoma Montgomery If Under 1 Yeer 5. Sociel Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 6 Sex 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Hours Min 1 M 20 F Months Deys Yrs. 111-16-4315 74 Director AUG. 20. 1924 New York Usuel Residence of Decedent the Marylenc 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Howard Director Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6336 Cedar Lane #182 Funeral 21044 USA death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. e filed within 72 hours efter el Hygiehe. 1 ∑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 X Married Maryland 21215-0020 1 ☐ Yes 2 🕅 No Specify: P white 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 General Manager Pest Control 17. Fether's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill mant of Health end Mentel Hy lant: If itam 27 is marked oth Hugh Gordon Hannah Sarfaty 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Marguerite H. Gordon - wife 6336 Cedar Lane #182, Columbia, Md. other t altimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) Date 20c. Location - City or Town, Stete 3/10/99 permit. Pages Depertment of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) St. John's Luth. Ch. Cem. Columbia, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md. 21075 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediata Ceuse (Finel diseese or condition resulting in daath) Examiner F 2-12-99 Examiner physician and the buriel-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 98 950 0 Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobecco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? has page 2 2 DINO 20 No certificata 1 Yas Mospital or Attending Physician: 24 hours after death. Funerel Director: After this certific director, 25. Wes case referred to medical axaminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yas 2 No 2 tunerel 27. Mannér of Deat 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending invastigation 1 Neturel 1 ☐ Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of tnjury - At homa, farm, straet, factory, office building, etc. (Specify) 4 ☐ HomicIde Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and mannar es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifian Medical (Check only one) To the Within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddrass of person who complated cause of deeth (Itam 23a) (Type, Print) TUBAR CUASHINGTON

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32. Registrar's Signeture

DHMH 16 Rev 6/95

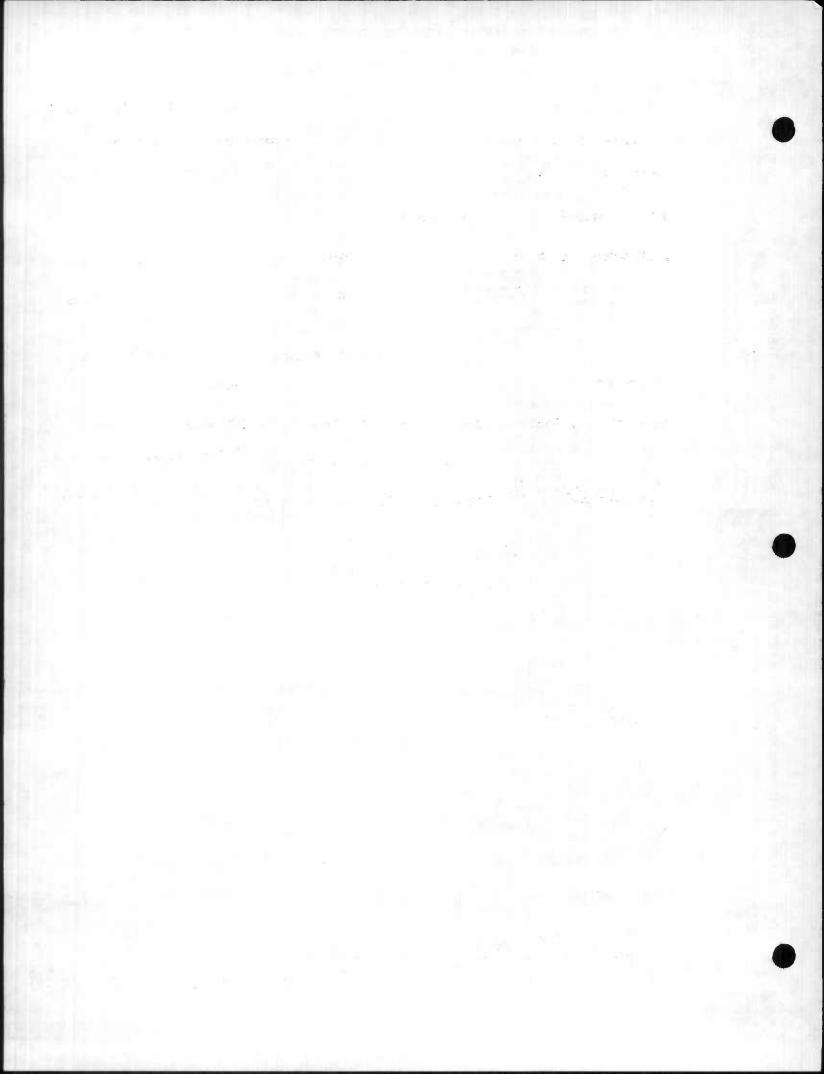
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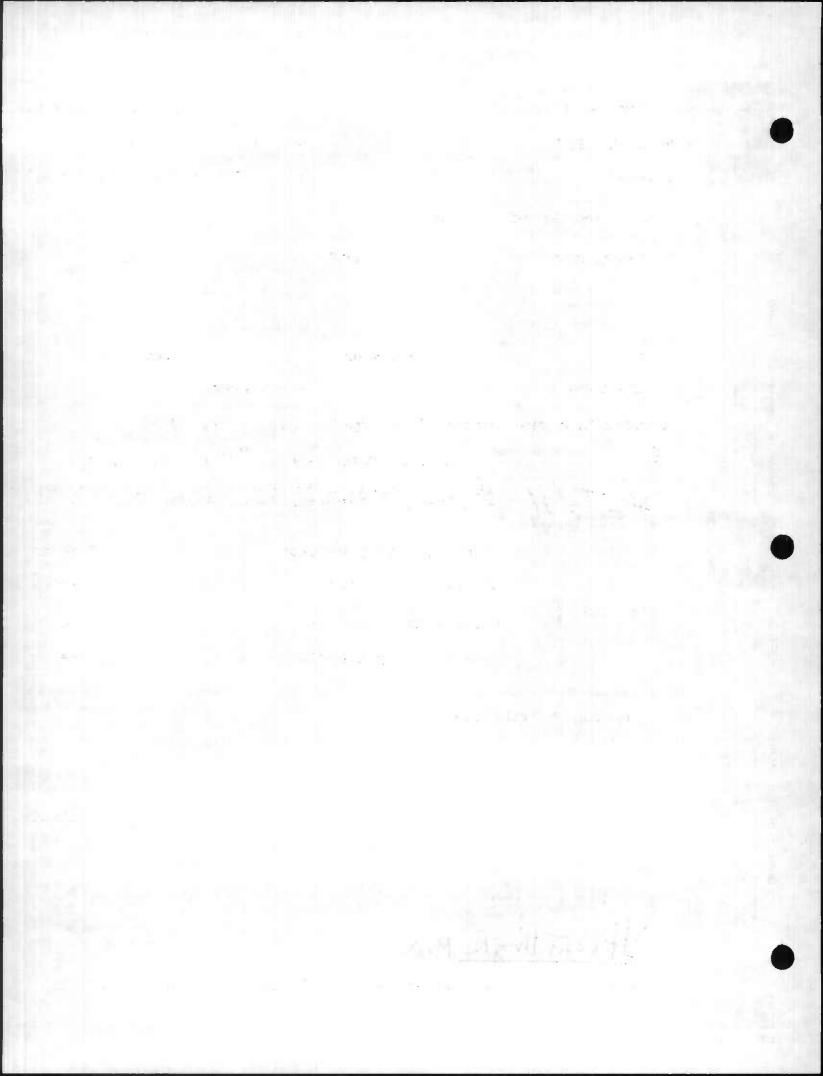
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) Dav Year Month **Physician** Kathryn Geyer 3:00 PM 03 99 04 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner N/A Baltimore Harbor Hospital If Undar 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthplaca (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 10 M 2 F 69 Yrs. Director 216-24-2263 FEB. 8, 1930 Missouri Usual Residence of Decedan the Merylend 10d. inside City Limits 10a State 10b County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Md. 1 ☐ Yes XX No Anne Arundel Hanover Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21076 7217 Ridge Road USA Funeral death 12. Was Decedant Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No tf Yas, Give Year or Datas: 13. Was Decedent of Hispanic Orlgln? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after nend Mental hygiene. 1s merked other than "natural", or tha 1 □ Navar Married 2 □ Married Maryland 21215-0020 1 Ves 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8 Homemaker Own Home traumatic event. 18. Mothar's Name (First, Middle, Maidan Surname) 17. Fethar's Name (First, Middle, Last) Be Albert Rogers Frieda Wischer 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peges 1 and 2 si nent of Health en ant: if item 27 is n 7206 Ridge Rd., Hanover, Md. 21076 Charlotte H. Rogers - sister other 1 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) Data 20c. Location - City or Town, Stata 3/8/99 1 XBurial 2 Cremation 3 Removal from State 0 permit. Pege Department of Important: If any Injury or pace. Loudon Park Cemeterv 4 ☐ Bonation 5 ☐ Othar (Specify) Baltimore, Md. 21, Signature of Funeral Service Licens 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md. 21075 Part Entar tha disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, or hear failure. List only one cause on each line. Approximata intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) 3 years Coronary Artery Disease Examiner Due to (or es a consequence of): Mitral Insufficiency Examiner 2 years physicien end s the burial-trens Sequentially tist conditions, if any, laading to immediate causa. Entar Undarlying Cause (Disease or injury that initiated avents resulting in daath) Last Due to (or as a consequence of): certificate be execu Chronic Renal Failure years Box 68760 Physician/Medical Dua to (or as a consequence of): 50 12 years Essential Hypertension USB ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? ed by the detached 0.0 1 Yee 2 No 3 Probably 4 Unknown Rheumatoid Arthritis signed l Division of Vital Records, A 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of daath? pege 2 s hes certificate 1 1 ☐ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was casa raferred to medical examiner? 26. Placa of Death (Check only one) Be Other: 4 Nursing Home 5 Residence & Other (Specify Dialysis Hospital: 1º 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27, Manner of Death 28d. Describe how Injury occurred 28b. Tima of 28c. injury at Work? Certification: After 5 Pending Invastigation Unit 1 Natural deeth. 1 ☐ Yes 2 ☐ No 2 Accident ofter deet Director: 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicida 24 hours e 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated edical 29a. Certifier stely (Check only one) To the I within 2 To the I complet 29d. Date signed (Month, Day, Year) 03/05/99 nd title of certifier 29b. Signature 29c. Licansa number D14160 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225 32. Registrar's Signature Registrar



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State Registrar MAR 0 9 1999

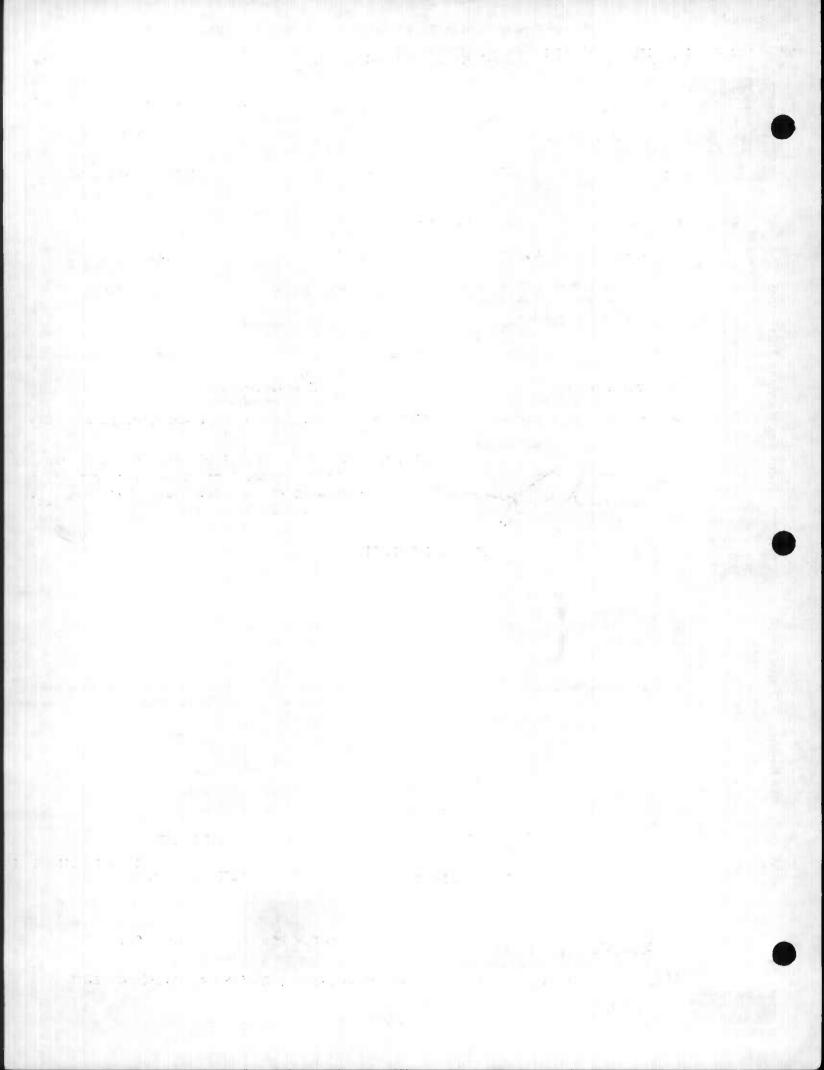
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82. Registrer's Signature

30. Neme end eddress of parson who completed cause of deeth (item 23e) (Type, Print)

. Sports

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death March 4, 1999 Elizabeth Myrtle Gallagher 5:30 AM 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore N/A St. Agnes Healthcare If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul. 2, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1□M 25 F 66 Yrs. 219-28-2965 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3623 MacTavish Avenue 21229 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Savings and Loan Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Vaughn Matthews Irene Seibel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Dennis P. Gallagher / Son 8617 Pine Circle, Charlotte, North Carolina 28215 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/8/99 Cedar Hill Cemetery Brooklyn Park, Maryland 22. Neme and Address of Fecility 21. Signature of Funeral Service Licenser Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart leiture. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final ADVANCE LUNG CANCER 2months disease or condition resulting in death) Due to (or as a consequence of): Due to (or es a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy lindings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one)

Physician /Medical Examiner certificate be axecuted physician and s the burial-transit

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked othe any injury or other traumatic event, once.

Baltimore, Maryland 21215-0020

Box 68760.

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Records.

Division of Vital

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical axaminer? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 18 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, Ierm, street, fectory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. mination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

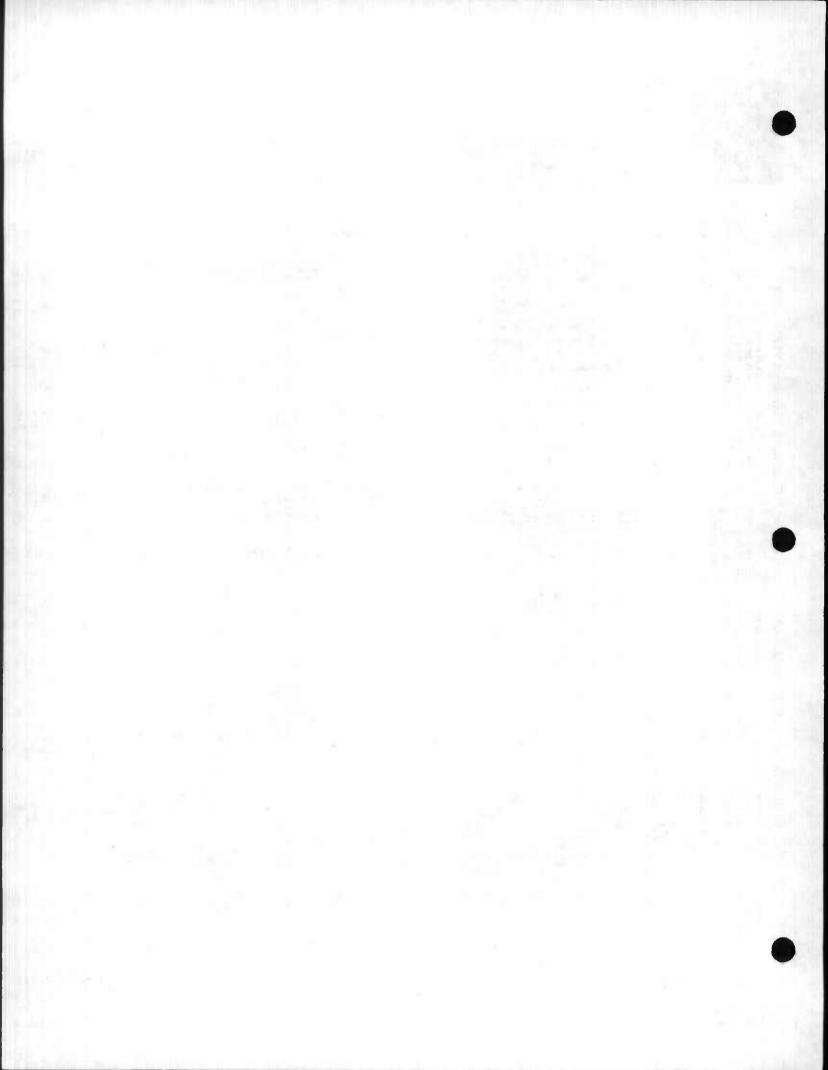
29d. Date signed (Month, Day, Year) HAR 6 1999

M.D. 30. Name and address of person who co repleted cause of death (Item 23a) (Type, Print)

AUENUE, BALM NOVE, MD MAICIMMICIAN KAWMIEC SOO CATON

15235

State Registrar 31. Date filed (Month, Day, Year) MAR 0 9 1999 32. Registrar's Signatura



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth GAVIN Dev **Physician** SIAMES 5, 1999 MARCH 1:45 P.M. /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner JOHNS HOPKINS HOSPITAL BALTIMORE CITY
if Under 24 Hrs. 8. Date of BALTIMORE If Under 1 Year 8. Date of Birth (Month, Day, Year)
Nov. 3,1930 Birthplace (State or Foreign Country) 5. Sociel Security Number 6 Sav 7. Age (In yrs. last birthday) **Funeral** 1- M 2□ F Months Deys Hours Min Yrs. 244 44 3471 68 Director Nov. North Carolina Usuei Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rie 23a or 28a-f shov must be notified at n/a Maryland Baltimore 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 527 N. Castle St. 21205 United States Funeral 12. Was Decedent Ever in U,S. Apped Forces? 14∑ Yes 2 □ No If Yes, Give Yeer or Detes: than "natural", or items the Modical Examiner in 11. Meritel Status [Jnknown 14. Race - American Indian, Bieck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Black Specify: p 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 7 nant of Health and Mentel Hygiene. nt: If itam 27 is marked other than "r Elementery/Secondary (0-12) College (1-4or 5+) Steel Mill Mill Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) (Unknown) Gavin (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Kevin Gavin / Son 527 N. Castle St., Baltimore, MD 21205 other 1 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei Irom State 20c. Location - City or Town, Stete Depertment o important: If eny Injury or 0 Green Mount Crematory 3/8/99 Baltimore, MD 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility
CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 let Melina 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) HYPERCALCEMIA DAYS Examiner Due to (or es e consequence of): Examiner MONTHS SQUAMOUS CELL CARCINOMA Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lasl Due to (or es e consequence of): physician and the burial-tren Physician/Medical Due to (or es e consequence of): 88 nse Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yss 2 No 3 Probably 4 Unknown A Q 24b. Were autopsy findings eveileble prior to Completed 24a. Was an autopsy performed? peen completion of cause of deeth? page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Be Hospital: 1 Anpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 5 Pending investigation 1 Naturei if or Attending after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours TE Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. edicai 29a. Certifier To the Vithin 2 To the I comple 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier 2ES-000 MARCH 5. MO

certificate be axe Box 68760 Division of Vital Attending

altimore, Maryland 21215-0020

State Registrar

31. Dete liled (Month, Day, Year)

MAR 0 9 1999

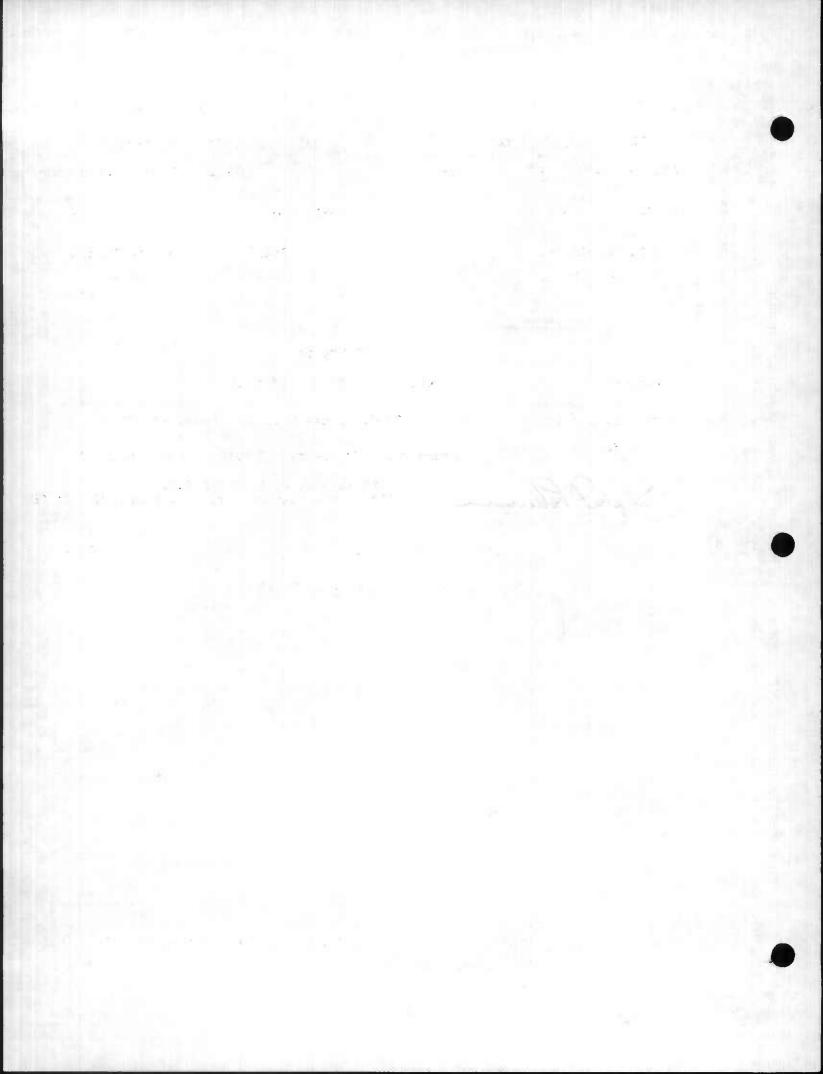
JEAN WANG, MD, JOHNS HOPKINS HOSPITAL, TOWER 110, 600 N. WOLFEST. 32. Registrer's Signeture

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

Conto

RALTIMORE, MD

2128



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month =20am Name (If not Institution, giva street and number) 1999 Jan c 4b. City, Town, or Location of De 4a Facility 4c. County of Death AGNES 017 HOSPITAL BAltimore Hours Min. 8. Date of Birth (Month, Day, Year) Aug 12,1950 If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 20 F Days Months 48 UNKNOWN New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Baltimore 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 325 Westowne Rd. 21229 United States 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ② ② No If Yes, Give Year or Detes: 11 Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify White 3 ☐ Widowed 4 💆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Tavern/Bar Bar Tender 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Robert Gorton Violet. Yates 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Syreta E. Stewart / Daughter 2817 Rueckert Ave., Baltimore, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State Green Mount Crematory 3/6/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset end Death Immediate Cause (Finet disease or condition resulting in death) Dua to (or as a consequence of) Due to (or es a consequence of): Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings 24a. Wes an autopsy performed? aveilable prior to completion of cause of death? 2 No 2DI No 1 Yes 1 Yas 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work?

100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

20 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner steted.

29c. License number

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

permit. Page Department of Important: If any Injury or

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

Director

Funeral

þ

Completed

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"natural", or items 23a or 28a-f ahov adical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after of the should be filed by the should be shou

Baltimore, Maryland 21215-0020

the Maryland

with

death

Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events that initieted events resulting in death) Lest þ Completed

27. Manner of Death

1 Neturel

2 Accident

3 Suicide

29e. Certifier

4 Homicide

29b. Signature and title of certifie

MAR 0

5 Pending investigation

6 Could not be

M, Day, Year)

1999 9

physician and s the burlal-transit The law requires that the deeth certificate be axecuted Box 68760. USB 88 1 signed by the a P.O. of Vital Records, page this After Division Attanding death. Director: A In by 8

in 24 hour.
o the Funeral Decomplately fille within 2 To the SEP .

Hospital

State

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edicai Certification: To

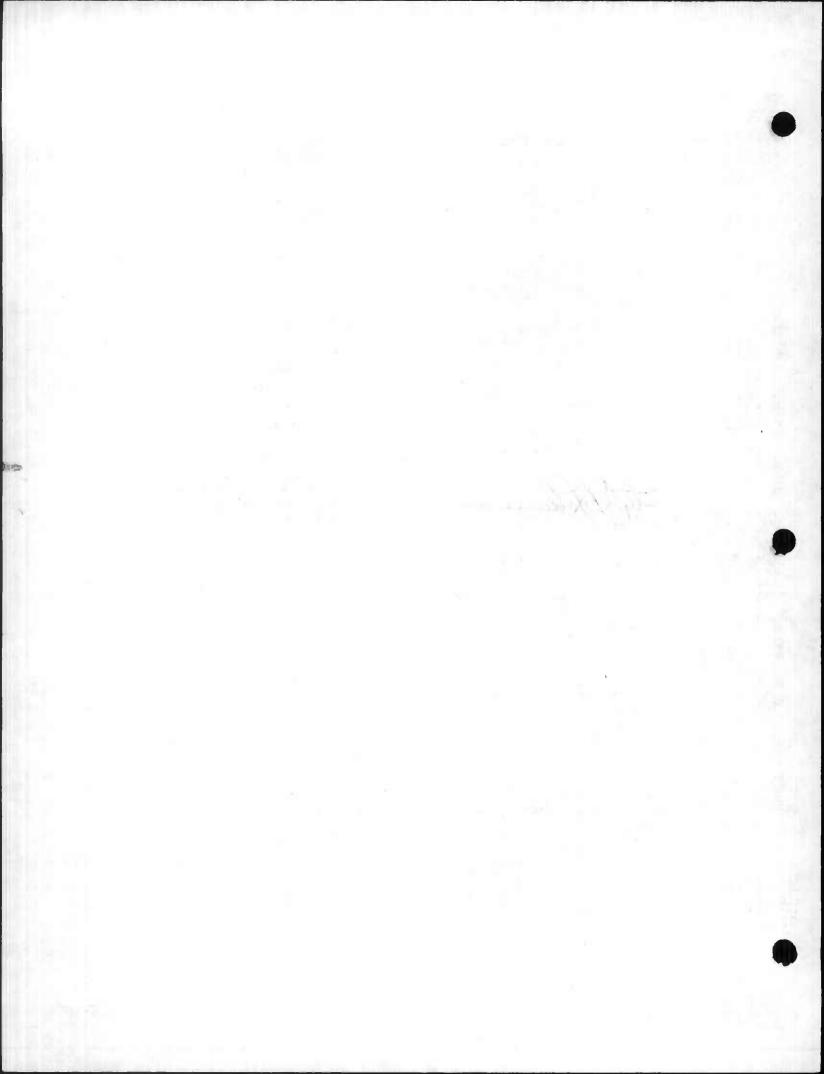
Injury

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Dete of Injury (Month, Day Yeer)

completed cause of death (Item 23a) (Type, Print)

132. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Daath GIVEN MARCH 1999 KATHRYN 4 6:45 PM 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Future Care Chesapeake Arnold If Under 24 Hrs. Anne Arundel 7. Aga (In yrs. last birthday) 83 Yrs. If Under 1 Yaar 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 6. Sax 1□M 2X F Months Days Hours 217-10-0108 August 5,1915 Maryland Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Anne Arundel Pasadena 10f. Zip Code 10a. Street and Number 10g. Citizen of What Country? 601 McMagan Drive 21122 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No if Yas, Giva Yaar or Datas: 14. Raca - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married White 1 Yas 2 No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Household 12 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Unknown Millie Albaugh 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Hagan daughter 601 McMagan Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burial 2 Cramation 3 Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Woodlawn Cemetery March 8 Baltimore, Maryland 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 work of antar the mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Batween Onset and Death 23a. Part 1. Entar tha disaasa, or complications that causad the death shock, or heart failura. List only one causa on each line. Immediata Causa (Final disaasa or condition rasulting in death) Due to (or as a consequence of) umoni Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disaase or injury that initiated avents resulting in death) Last Dua to (or as a consequence of) Ima Dua to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? 1□ Yaa 2√ No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy ane 1 Yas 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner physician end s the burial-transit certificate be executed

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signed by the a

Physician

/Medical

Examiner

Directo

Funeral

Be

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Funeral

Director

28a-f

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netural, or items 23s

Hygiene.

permit. Pages 1 and 2 should be f Department of Health and Mental P important: If Item 27 is marked of

altimore, Maryland 21215-0020

Records, P.O. Box 68760,

Division of Vital

Examiner Physician/Medical by Completed 80 Certification: To

Medical

29a. Certifier

Part It. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Part It. coronary 25. Was casa ratarred to medica axaminar? Other: Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 27. Manpar of Death 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of 1 Natural
2 Accident 5 Pending invastigation

28a. Data of Injury (Month, Day Year)

28c. Injury at Work? 1 Yes 2 No

29c. License number

6 Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

(Check only one) 29b. Signature and title of certifiar

29d. Data signed (Month, Dav. Year)

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

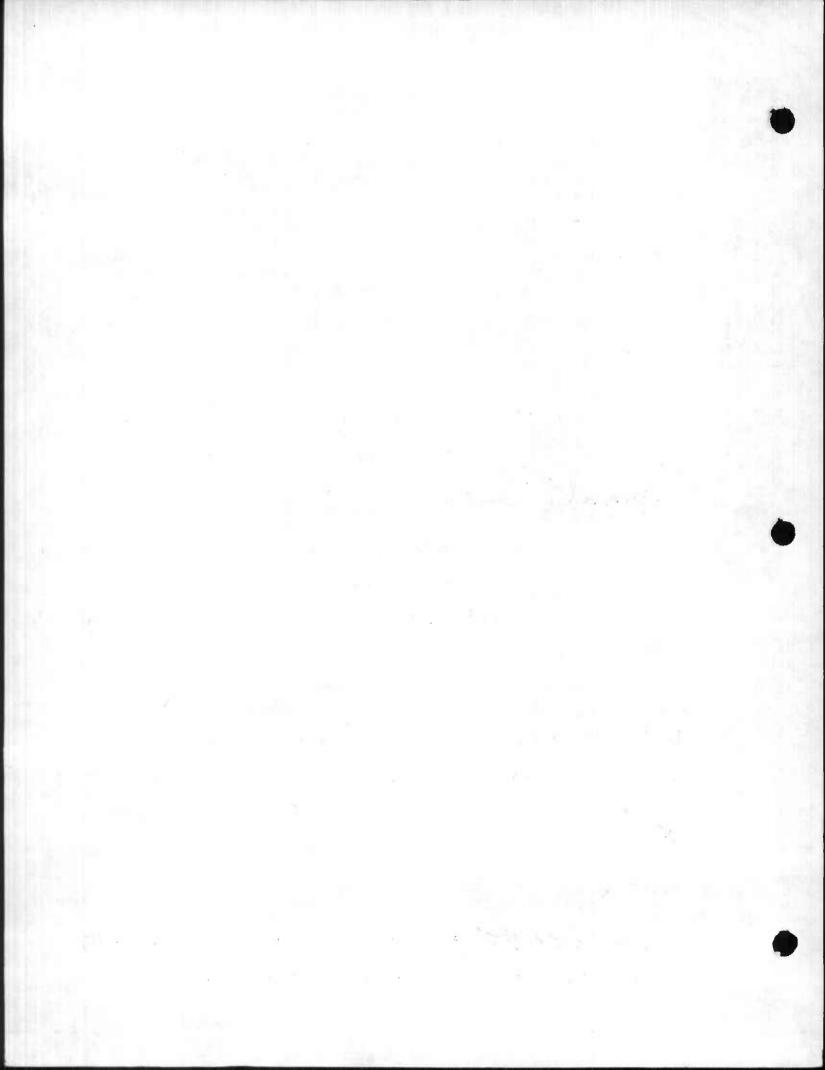
Dr Rebecca Elon 1454 Baltimore Annapolis Blvd. Arnold.MD 21012

State Registrar

31. Data filed (Month, Day, Year) MAR 9 1999 32. Registrar's Signatura

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month March **Physician** Mary S. Godwin 10:50 pm. /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Cherrywood Health Care Center Reisterstown Baltimore If Under 24 Hrs. If Under 1 Yeer 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year)
March 10, 1904 Maryland **Funeral** 1 M 2 DE Months Deys Hours 216-09-2107 94 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Md. Baltimore Reisterstown 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 108 Nicodemus Road 21136 U.S.A. Berra 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: t4. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 72 hours after 1 Never Merried 2 Merried natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 □ Divorced White permit. Pages 1 and 2 ahould be filed within 72.
Department of Health and Mental Hygiers, important; if Nem 27 is marked other than "natus any injury or other trainmatic event 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Western Union Clerk 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be dohn F. Swain Mary Elizabeth Woolmer 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) James K. Richmond - nephew 2 Noves Ct. Silver Spring Md. 20010

20b. Place of Disposition (Name of cametery, cremetory or other place)

20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) Evergreen Mem. Gardens March 10, 1999 Finksburg, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Eckhardt Funeral Chapel Ell 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete tntervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical Examiner Physician/Medical Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Box 68760 thet initieted events resulting in death) Lest Due to (or es a consequence of): P.O. I signed by the a Pert II. Other eigniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were autopsy tindings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitet: Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√0 Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Beath 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Haturet 1 ☐ Yes 2 ☐ No A after death. Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner steted. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture end title of contiline 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

BMD

32. Registrar's Signeture

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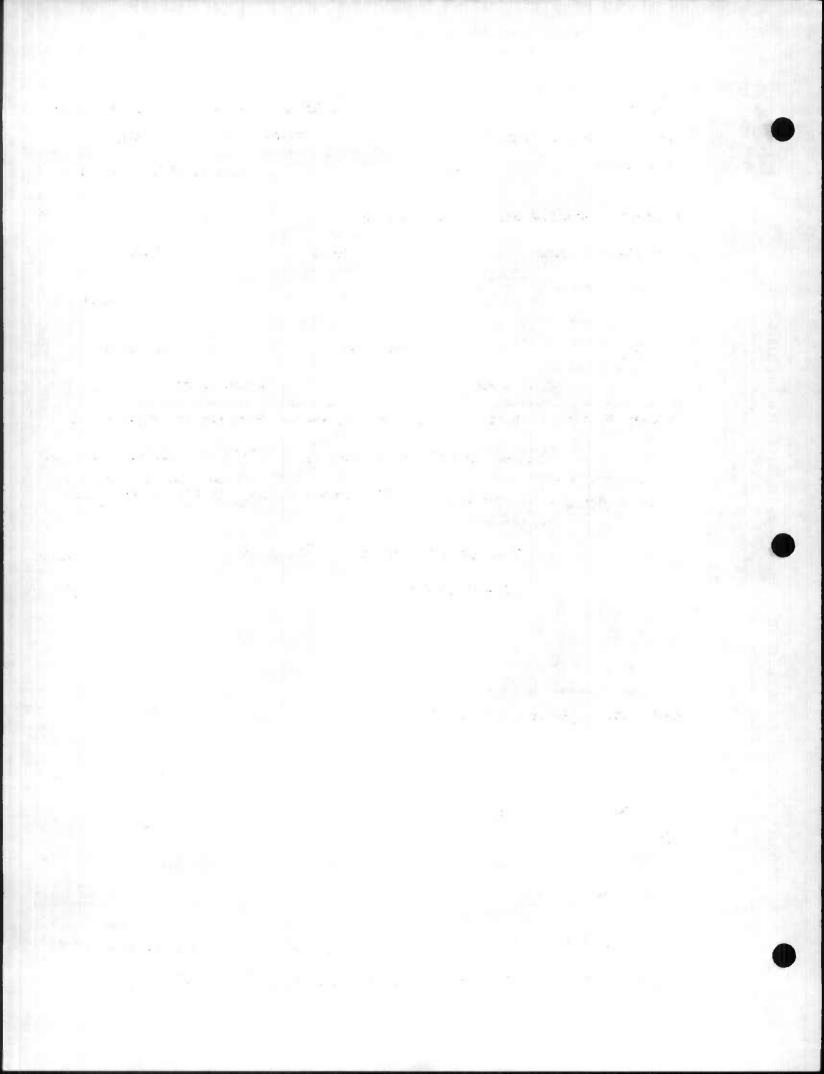
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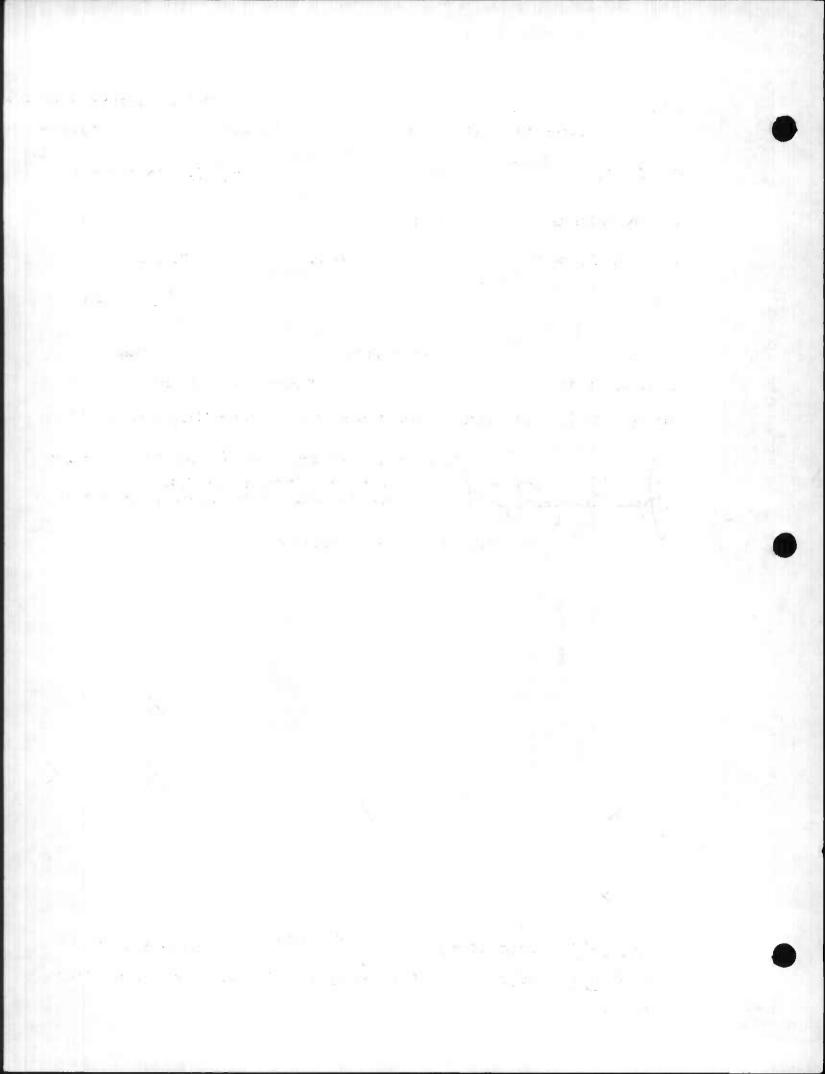
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Yeer **Physician** JULIA GARVEY 1999 MARCH 6. /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE CITY N/A THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year)
June 7, 1939 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** 1 M 280 F Months Deys Hours 216 36 9589 59 Yrs. Virginia **Director** Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Manyland ment of Health and Mantal Hygiene.
ant: If item 27 is marked other than "naturel", or items 23s or 28s-f ahow ury or other than "naturel", or hone is an unit be notified at ury or other traumatic avant, in Modical Examiner must be notified at 10c. City. Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Glen Burnie Directo 10e. Street end Number 10f Zip Code 10g. Citizen of Whet Country? 345 Stiemly Avenue 21060 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Detes: 14. Raca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Bleck, White, etc. 1 Never Merried 28 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorcad White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12th 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Susie Havey John Savko 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Thomas Garvey / husband 345 Stiemly Avenue Glen Burnie, Maryland 21060 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If eny Injury or 3/10/99 Cedar Hill Cemetery Baltimore, Maryland 4 Donetion 5X Other (Specify Entombment 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel HEART CONCESTIVE disease or condition resulting in deeth) Examiner Examiner la years SCLERODERMA physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): for use es 1 the Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? ed by the 1 Yes 2 No 3 Probably 4 Unknown STAGE þ sign 1 be 24b. Were eutopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? cartificate has t 2X No 1 ☐ Yes 28 No Hospitai or Attanding Physician: 24 hours aftar death. Funeral Director: After this carifice director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To funeral 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 4 ☐ Homicide in 24 hour.
The Funeral Direction of the control of Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and manner stated. 29e. Certifier To the Hosp within 24 hou To the Fune completely fi edicai 29d. Date signed (Month, Dey, Year) 29b. Signature and who cartifier 29c. License number RFS-000 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) BOCTOR LOUNGE, JOHNS HORKINS HOSP MAN AVID 10WER LIBAR 110 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 2. New MAR 9 Registrar



	1. Decedent's Name (First, Middle	Last)	08	ertificate d	Deall	2. Date of Dee		3. Time of De	ath			
Physician	Selma	Α.		Gud	lan	MonthMAI	RCPAY 03	,Yea 599 4:40	h P.			
/Medical Examiner	4a Facility Name (If not institution, Saint Jose	giva straet and number	1 Center		4b. City, Town,	or Location of Death	4c. County	of Death Baltimore	2			
uneral rector	212-46-2512	6. Sax 1 □ M 2 1 F	ge (In yrs. last birthda) 83 Yrs.	/) If Undar 1 Ya Months Da		in. (Month, Day	Year) 1915 I	9. Birthplaca (Stata or F Country) Maryland	oraign			
	Usual Residence of Decedent 10a. State 10b. County					10d. Inside City I	Limits					
notifiedat	Maryland Baltimo	ore	Baltimore	2				1 ☐ Yes 2	ØNo			
Director	10e. Street and Number		20202002	10f. Zip Cod	le	1	log. Citizen of V	Whet Country?				
aiD	1000 Franklin Av	renue		21	221		U.S.A.					
by Funeral	11. Marital Status 1 ☐ Never Marriad 2 ☐ Marria	12. Was Decedan Armed Forces ad 1 Yes 24 If Yes, Giva	? INo		of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ca - American Indian, ck, White, etc. White				
Completed b	3 XiVidowed 4 ☐ Divorced 15. Decedent' (Specify only highes	grade completed)	16a. Dec (Giv	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)				usinass/Industry				
ф	Elementary/Secondary (0-12)	College (1-4or	5+)	e Wife			Own Ho	n Home				
e C	17. Father's Name (First, Middle, L	ast)	, noas	C WIIC	18. Mother's N	lame (First, Middla,						
To Be	August W. Gutche	er			Theresa	a W. But	zner					
	19a. Informant's Name/Relationsh Shirley J. Picke					Rural Route Number Sykesvill		State, Zip Code) yland 21784				
	20a. Method of Disposition	0 III	Ramoval from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory				20c. Location - City or Town, State 99 Baltimore, Maryl					
	4 Donation 5 Other (Sp								1			
pnce.	21. Signature of Funeral Cervice Libensee 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 212											
an cal ner	23al Paht1 Enter the disease, or shock, or heart failure. List of limmediate Ceuse (Final disease or condition resulting in death)		E MYOCAR	DIAL I				Interval Betwee	en ath			
ai Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	b									
edicai	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or as a conso	equenca of):								
lan/N		d										
Physic	Part II. Other algnificant condition	es contributing to death	but not resulting in the	underlying cause	given in Part I.	23b. Did to		ntribute to the cause of d 3 Probably 4 □ Ur	death? nknown			
leted						24e. Wes e	en eutopsy med?	24b. Were autopsy find availabla prior to completion of cau of death?				
tor, page 2						1□ ∨	'as 2 No	1 Yes 20 No	0			
5 0	25. Was case referred to medical				26. Place of I	Death (Check only or	ne)	.2.00				
To B	examiner?	Hospital:	ient 2 ER/Outpati	ent 3X DOA	Other:	sing Home 5 Residence 6 Other (Specify)						
ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of In (Month, D	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?				28d. Describe how injury occurred					
edical Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Place of I	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Straet and Number or Rural Route Number, City or Town, State)			or,			
completely filled in b	29a. Certifier Check only one) Certifying	Physician: To the bes xaminer: On the besis and manner s	of examinetion and/or	ath occurred at th investigation, in n	e time, date and pla ny opinion, deeth o	ace, and due to the occurred et the time, o	cause(s) end made and place,	enner es stated. and due to the cause(s)				
W com	29b. Signature end title of cartifier		29d. Date signed (Month, Day, Year) March 3, 1999									
0	30. Name and address of person v	ho completed cause of	death (Item 23a) (Type 1. I)., 762	e, Print) 11 OSLE	R DRIVE	TOWSON,	MARYL	AND 21204				
State	31. Date filed (Month, Day, Year)		trar's Signature									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 0 7 1 1

	Decedent's Neme (First, Middle, Le			Certificat			2. Dete of Dec	Reg. No.		3. Time of De	eeth
Physician	Ernst Hermann			Month	Dey Yeer 7. 1999						
/Medical	4a Fecility Name (If not institution, gla		4h City Town or	March Location of Death			9:30	AM			
Examiner									6.0		
	4209 Darnall Roa 5. Social Security Number 6.5		ne (In urs lest hirthday) If Under 1 Y			Baltimo		Baltin			Familia
Funeral Director					Deys	ys Hours Min. May 14		y. Year) 1914	ece (State or F Cand	oreign	
h the Maryland r 28a-f show	10a. State 10b. County		10c. City, Town				10			od. Inside City Limits 1 ☐ Yes 2 🗓 No	
Set of Set	Maryland Baltimo	re			tim	ore					7 3
ufar death with the Manyland ritems 23s or 28s-1 show close must be notified at Funeral Director	10e. Street end Number 4209 Darnall Roa	d	10f. Zip Code 21236					U.S.A.	Citizen of Whet Country?		
# 5 3 U	11. Marital Stetus 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	If Yes Give		If Yes, specify Co			Specify Yes or No- rto Rican, etc.)	14. Race Blec Specify	en Indian, etc.		
	15. Decedent's Elementery/Secondery (0-12)	ide completed)				cedent's Usuel Occupation iva kind of work done during most of work b. DO NOT use retired) LChasing Agent		16b. Kind of Business Private In		Real Education	
Cor transfer		2	P	wichasir	ig A	-				isiry	
arytand 212 should be filed withir nd Mental Hygiena. marked other than umatic avant, the M	17. Fether's Neme (First, Middle, Last						18. Mother's Name (First, Middla, Maiden Sumama) Lyndia Emrich				
Nore, Marylis ges 1 and 2 should it of Health and Mer if item 27 is marks or other treumstic	19e. Informant's Neme/Reletionship Mrs. Thelma B.						Baltimor		Stete, Zip	Code)	
1 end 1 Health Health Sem 27 Inther tr	20a. Method of Disposition			Disposition (Na	ne of		Date	20c. Location -	City or To	wn, Stete	
Baltimore, Më pemir. Peges 1 end 2: Department of Health at Important: If them 27 is any Injury or other trea ans any Injury or other trea	1 X Burial 2 Cremation 3 C 4 Donation 5 Other (Special	y)	emoval from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) Gardens of Faith Cem.				3/10/99	99 Baltimore, Maryland			ıd
Baltim permit. Pe Departmen Important: any Injury	21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, Intervel Batwonset and Onset end Droset end										
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition rasulting in deeth)	a. 14	ment	consequence of)	~					Onset end De	eth
certificate be executed dring physician accused use as the buriel-transit		b	Due to (or es e o	consequence of):							
death cer death cer de ettendin de for use	De all Other de litter à constant		A A Mi 1	46		on in Book	oob Did	• • • • • • • • • • • • • • • • • • •	andhusa a a	the sever of	ete este f
that the de detached	Pert II. Other significant conditions of	ontributing to death b	Deser	the underlying o	ause gr	ven in Part I.		23b. Did tobacco use contribute to the cause of deeth			
requires yeen sign should be								an autopsy ormed?	ave coi	ere autopsy find eilebte prior to mpletion of cau deeth?	
VITAL REC sician: The law cartificate hes t director, page 2 s							10	Yea 2 No	10	Yes 2□ N	0
cartificate lirector, pa						26. Piece of Do	eeth (Check only o	ona)			
Physician: This cartific ral director,	axeminer?	Hospitat:	ent 2 ER/Ou	tpetient 3 D	DA Ot	Other			ar (Specifi	y)	
Phys r this eral di		28a. Deta of Inju (Month, De			28c. Inju			5 ☐ Meatdence 6 ☐ Other (Specify) Describe how Injury occurred			
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	2 Accident Investigation M 1 Yes 2 No								er or Rura	l Route Numbe	er,
Hospita 24 hours Funeral etely filled	29a. Certifier 1 Certifying Pl (Check only one) 1 Medical Example 1 Medical Example 1	ysician: To the best ninar: On the basia o end menner st	axamination en								
Me Me	29b. Signature and title of certifier	5/10 (110111101 51		29	c. Licen	se number		29d. Dete signe	d (Month.	Dey, Year)	
) F.¥58	1 Thoul	1 Konl	M		0 1	4743		3	819	9	
JOX	30. Nama and addrass of person who			Type, Print)	20	Bulte	une M	d 212	236		
State	31. Dete filed (Month, Day, Yeer)		ar's Signatur	Loon	41						

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedeni's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day **Physician** HANDEN MARCH 5, 1999 10:15 PM S. ALLEN /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL GENERAL HOSPITAL GLEN BURNIE ANNE ARUNDEL # Under 1 Year | # Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | SEPT. 4, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months tMM 2□F Director 68 220-28-6776 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County t 0d. Inside City Limits 1 Ves 2 □ No Director ANNE ARUNDEL ANNAPOLIS 28e-f t 0g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ð 5 KING COURT 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Apped Forces? 1 È Yes 2 □ No ARMY Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Merital Status Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: 'natural', or Specify WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 5+ College (1-4or 5+) Elementary/Secondary (0-12) ATTORNEY LAW Pages 1 and 2 should be filed nant of Health and Mental Hygi int: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) HANDEN DORIS SIEGEL HESSE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) t 9a. Informent's Neme/Relationship (Type, Print) Important: If Item 27 is any injury or other trea 5 KING COURT - ANNAPOLIS, MD ANNE HANDEN / WIFE 20b. Place of Disposition (Name of cornetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/8/99 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) ANSHE EMUNAH AITZ CHAIM 22. Name and Address of Facility 21 Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) · ARTERIOSCIEROTIE CARDIOVASCULAR 10 YEARS Examiner Due to (or as a consequence of): DISFAST Examiner physician and the burial-transit tha death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): 68760 Physician/Medicai Due to (or es a consequence of): USB AS Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 | Yes 2 | No 3 | Probably 4 | Unknown 00 STROKE signed t Records. þ 24b. Were eutopsy lindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed CHRONIC ATRIAL FIBRILLATION 1 Yes 2 No t ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) t□Yes 2□No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attanding 5 Pending investigation To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, lerm, street, lactory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Cartifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

31. Date filed (Month, Day, Year) State Registrar MAR 9

filledy

32. Registrar's Signature

NO

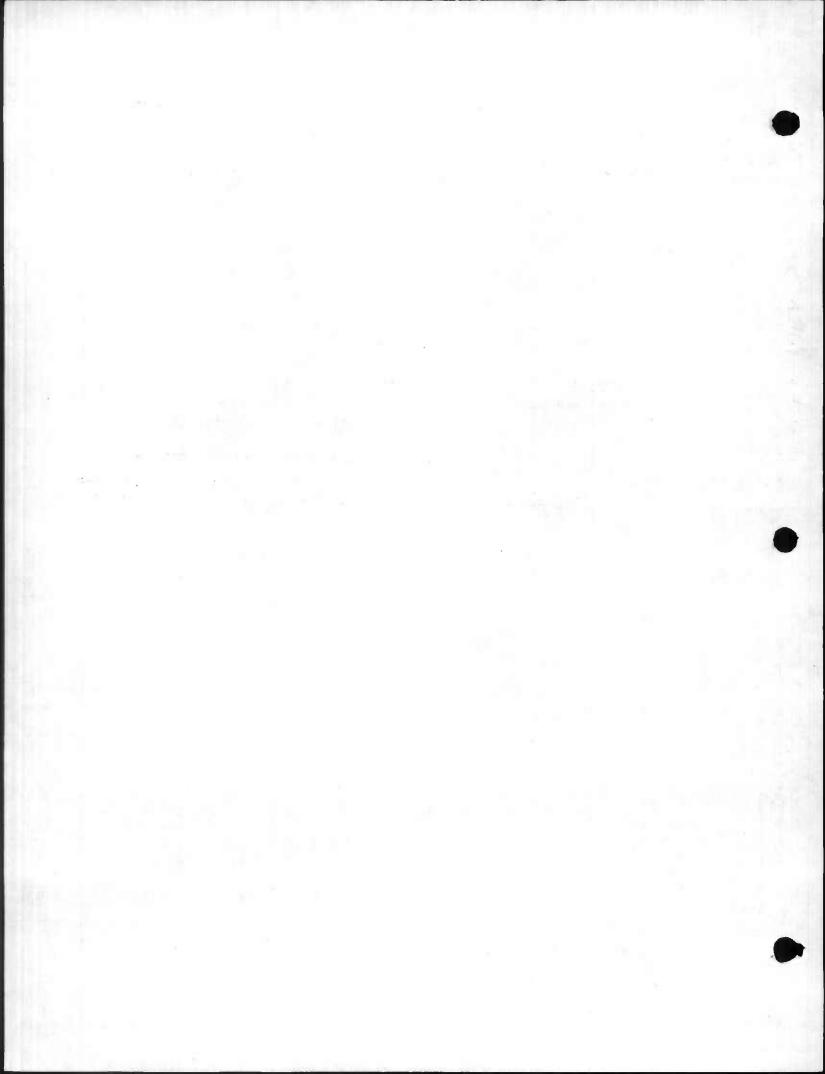
30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

C. 10110 01110000 Mn RIVG RITCHE HWY PASAPENA MO ZIIZZ

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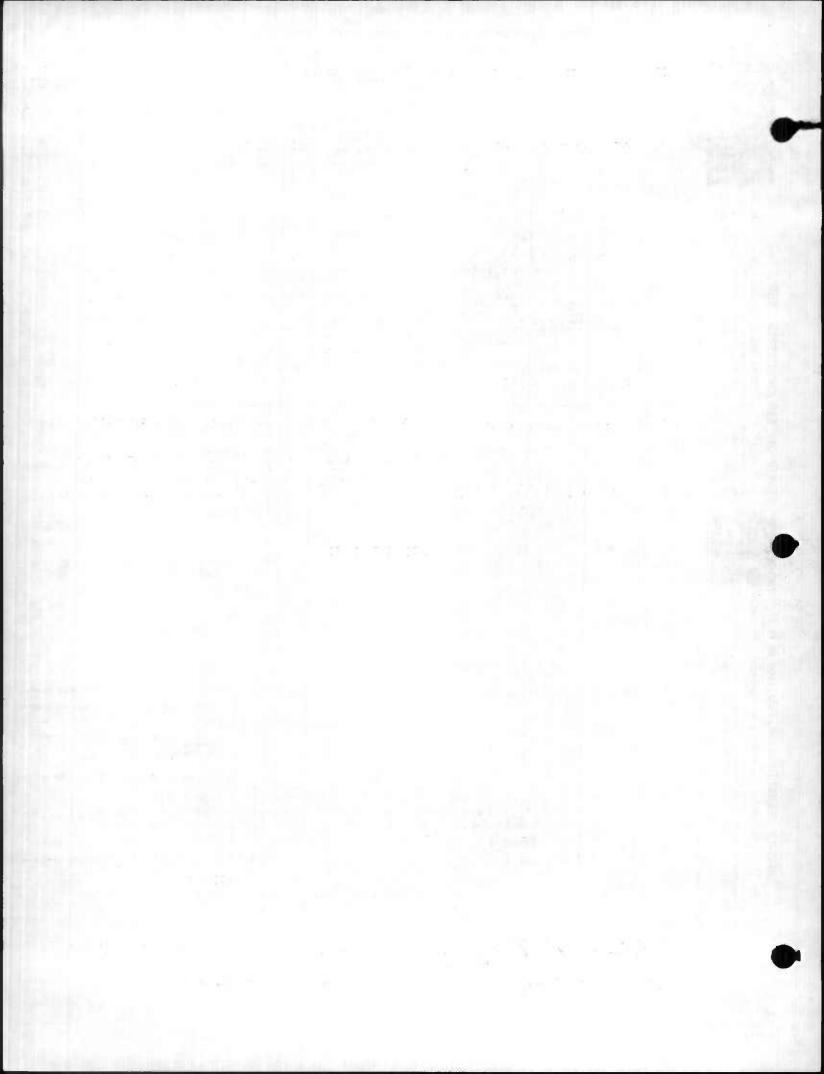
1999

MARCH



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	_	ITEMS: #23 PARTI, 27, 28A-F PER MEO G769 Certificate of Death Decedent's Name (First, Middle, Last)							eath Day	Day Year		
iysician Medical caminer	H	John Dean Hooley, Jr. 4a Facility Neme (If not institution, give street and number) 4b. City, Town,							Month Day Year MARCH 02,1999 Location of Death 4c. County of Dea		07:47	
	6.30 WEST LOMBARD STREET 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 1 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth									9. Birthple	ce (State or Forei	
neral ector	Usual Residence of Decedent									950 Maryland		
notified at		Oa. State 10b. County N/A			ty, Town or Locat Baltimo				100	I. Inside City Limit		
Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Code 23.0 TJ Tomboard Chroots										y?	
Examiner must be notified at	2	830 W. Lombard 1. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give	12. Was Decedent Ever in U,S. Armed Forces? If Yes			21201 us Decedent of Hispanic Origin? (Specify Yes or less, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2X No Specify:			USA 14. Race - American India Black, White, etc. Specify: White		
		15. Decedent's (Specify only highest g	Education rede completed)	cation 16a.			ccupation lone during most of wor etired)	16b. Kind of Bush		usiness/Indu	iness/industry	
omo:		Elementery/Secondary (0-12)	College (1-	4or 5+)	Never				Disab	led	ed	
To Be C	3 1	7. Father's Neme <i>(First, Middle, Lat</i> John Dear		Hooley			18. Mother's Nem Shir			ne)		
other traumatic event, the Medical		19a. Informant's Name/Reletionship					treet end Number or Ru					
5		John L. Arnold/S Oa. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	☐Removal from S	20b. Place of Disposition (Name of cemetery, cremetery or other place)				e. Baltimore, MD 212 Date 20c. Location - City or To 03/05/99 Baltimore,		City or Town	n, State	
DUCE.	21. Signature of Funeral Service Licensee Cremation Society o							ety of	of Maryland, Inc. Baltimore, MD 21228			
cian lical iner		23e. Part1. Enter the disease, or co shock, or heert faiture. List on immediate Ceuse (Final disease or condition resulting in death)	y one cause on ee	NA	ARCOTIC INT	TOXICA					nterval Between Onset and Death	
Examiner		Sequentially list conditions, fany, leading to Immediate cause. Enter Undertying Cause (Disease or injury	b	b								
e bu	2 1	het initieted events resulting in death) Last	Ç,	Due to (or as a consequer							
be detached for use as tr by Physician/Med	F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobecco use contribute to the cat			
should be detac										e autopsy findings labte prior to		
4 🖻							-	ins	pection	of de	ptetion of cause eath?	
director, page		25. Was case referred to medical					26. Ptece of De		1 Yes 2 No 1 Yes 2			
	2	examiner? 1 XYes 2 No	1			3□ DOA		·	idence 6 DOth			
completely filled in by the funeral di	2	27. Manner of Deeth 1 □ Natural 5 □ Pending 2 □ Accident investigat	on Found:	Day Year)	Found:	P 28c.	28d. Describe how injury occurred UNKNOWN					
Certification:		3 ☐ Suicide 6 ☒ Could not determine	building	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNKNOWN					28f. Location (Street and Number or Fura Royte Number City or Town, Stete) 830 W. LOMBARD STR BALTIMORE MD			
pletely fill edical				is of examina			he time, date and place my opinion, death occu					
Comp		29b. Signature and title of certifier	icense number	29d. Date signed (Month, Day, Ye MARCH 03, 1999								
	- 1											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1999 Richard George Haynes MARCH 05 3:18 PM 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 28 Drawbridge Court Catonsville If Under 24 Hrs. B. Date of Birth (Month, Day, Year) SEPT 30, 1925 Baltimore 5. Social Security Number If Under 1 Year 6. Sex 12 M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 220-12-2832 Yrs. 73 Maryland Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Catonsville 1 ☐ Yes 2 XNo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 28 Drawbridge Court 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1X Yes 2 □ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Anthony Haynes III Florence Loretta Yoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Carolyn Haynes/wife 28 Drawbridge Ct. Catonsville, MD 21228 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removel from State New Cathedral Cemetery 4 Donation 5 Dother (Specify) 3/9/99 Baltimore, MD 21. Signature of Funeral Service Licanses 22. Name end Address of Facility Mck Dawne MacNabb Funeral Home, P.A. McDonald 301 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as e consequenca of) Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4) Unknown 1 Yes 2 No 3 Probably 24b. Were eutopsy findings available prior to 24a. Was en autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

'natural', or items 23s or 28a-f show olds Examiner must be notified at

De.

Director

Funeral

λq

Be Completed

Lo

the Maryland

death

72 hours efter

filed within than

Pages 1 end 2 should be nent of Health end Mental

permit. Pages 1 end 2 Department of Health e Important: If item 27 is any injury or other trace

21215-0020

Baltimore, Maryland

bunial-tran the use es signed t page 2

requires that the death certificate be executed

The lew

Hospital

\$

Box 68760,

P.O.

Records,

of Vital Physician:

Division or Attending

Physician/Medical by Completed Be P Certification: Inby

director. After within 24 hours efter death. To the Funeral Director: A

State

Medical

completely

GORML 31. Date filed (Month, Day, Year) MAR 09 Registrar

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only one)

29b. Signeture and title of cartifier

5 Pending Investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) 22. Registrar's Signature

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 ☐ Yes 2 ☐ No

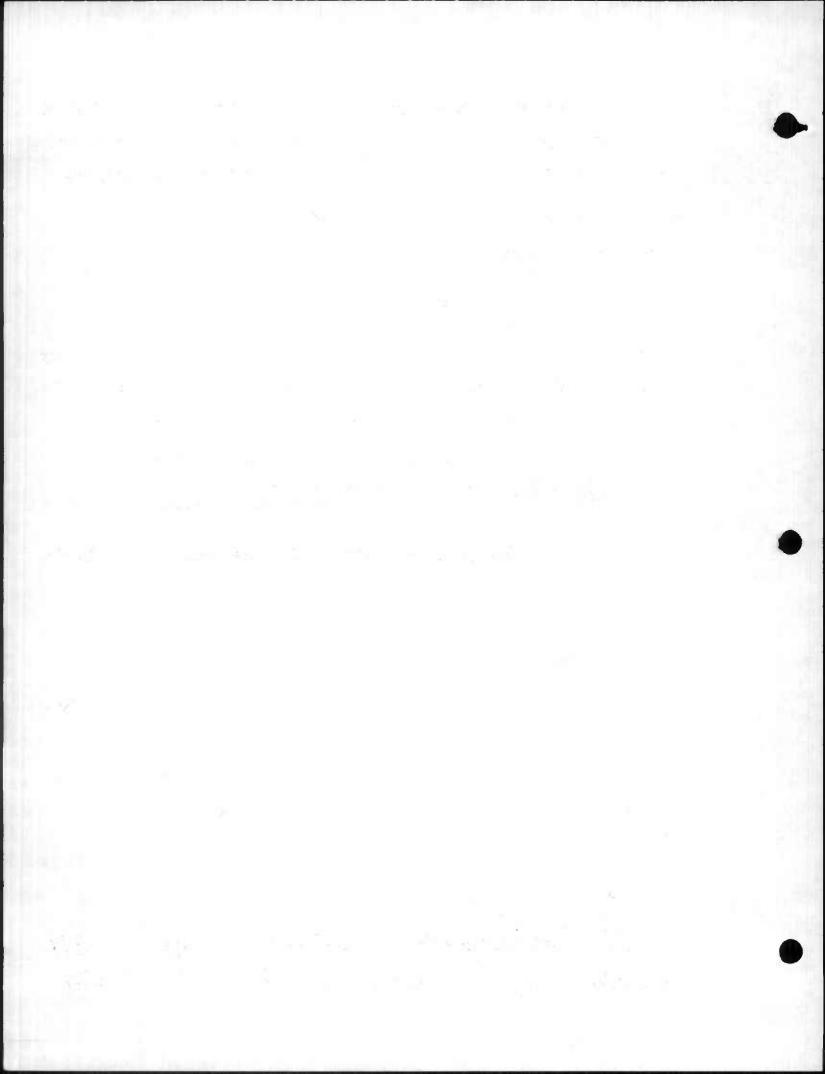
Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Dey, Year)



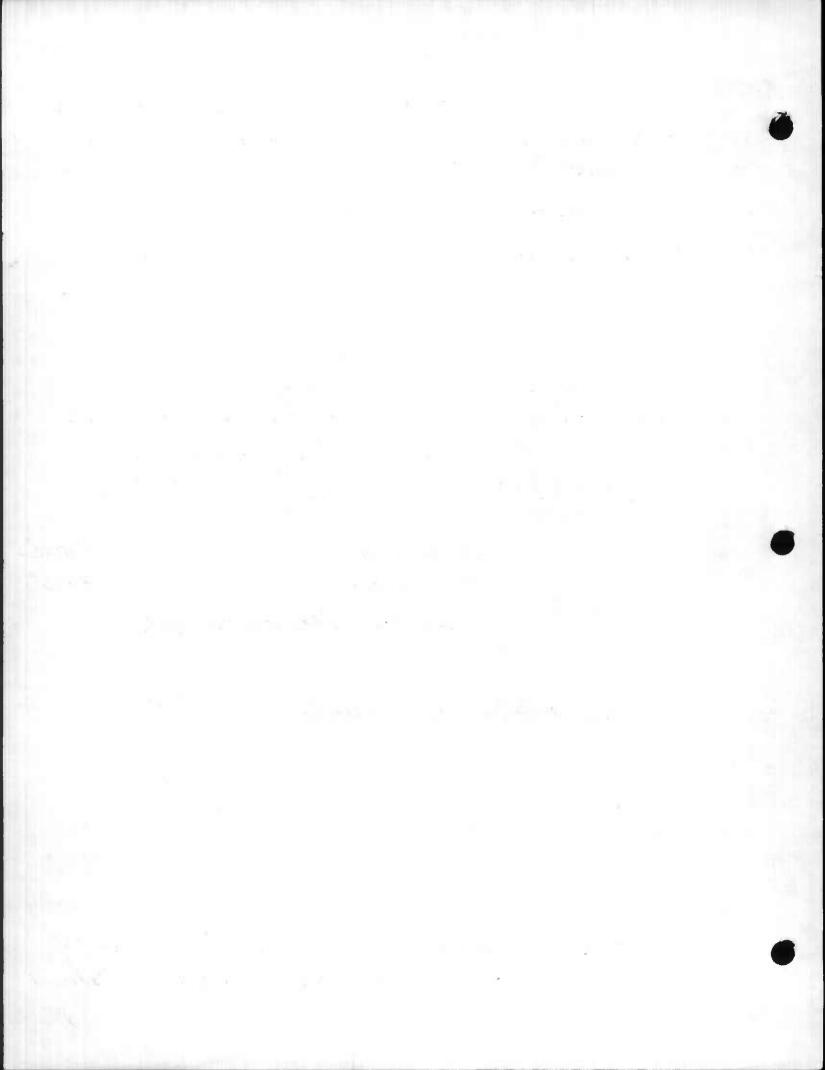
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey Yee **Physician** Anna Hastings Marie 1999 March 7:32pm/Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner 5506 Calvert Road Woodlawn Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys 10M X0F Months 25, 1908 Director 215-01-8755 DEC Maryland Usual Residence of Decedent the Merylend 10e. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, or Meolical Examinat must be nothled as 1 ☐ Yes 🏖 No Director MD Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21207 5506 Calvert Road USA Funeral death 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? 12 should be filled within 72 hours after on and Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 Housewife Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Pages 1 end 2 should be 1 Department of Health and Mental I Important: If item 27 is marked or UNK. Max Woelfer 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 5506 Calvert Road Woodlawn, MD 21207 Betty M. Matis/daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 6 03/08/99Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 22. Name end Address of Facility Cremation Society of Maryland, Inc. 21. Signeture of Funeral Service-Lipen (LUV) 10 Frederick Rd. Baltimore, MD 21228 McDonald Dawn 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) **Examiner** Examiner The lew requires that the death certificata be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest pue alzheimer's type Box 68760, physician Physician/Medicai Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by the 1 Yes 2 No 3 Probably 4 Unknown artentes with amaurosis þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24a. Wes en autopsy performed? peen page 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

Injury et | 28d. Describe how injury occurred 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3□ DOA After this funeral d 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of Certification: 5 Pending investigation 1 Natural 2 ☐ Accident daath. 1 ☐ Yes 2 ☐ No n 24 hours efter daath.

Funeral Director: A pletely filled in by the funeral pletely filled in by 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital edical TCCertifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner steted. 29e. Certifier pletely (Check only one) within 2 29c. License number 29d. Date signed (Month, Dev. Year) cause of deeth (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar 09



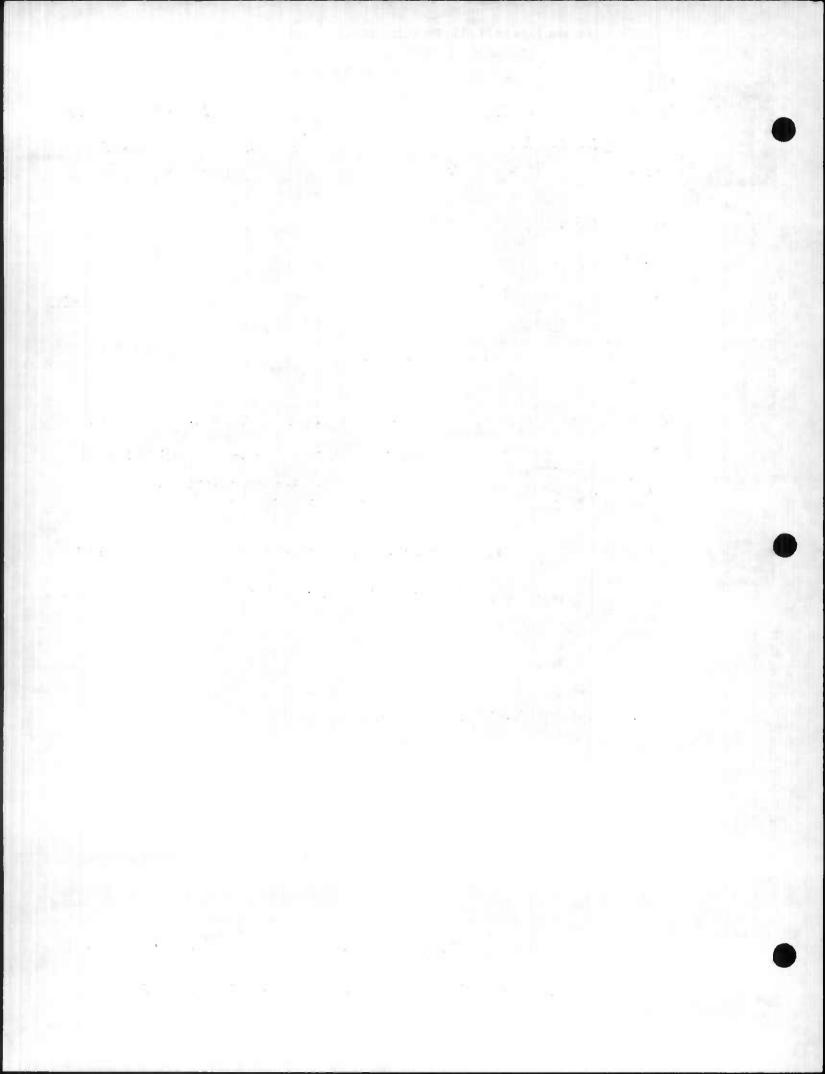
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death **Physician** 5,1999 MARJORIE A. March 5pm /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE

9. Birthplece (State or Foreign Country) HILLDALE 1220 RD. ROSEDALE If Under 24 Hrs. 7. Aga (In yrs. last birthdey) 82 Yrs. If Under 1 Year 6. Dete of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Deys Hours Min. 1□M 2√2 F 215 05 1952 Director MARYI AND Usuel Residenca of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland neat of Health and Mental hygiene.
ant: If item 27 Is marked other than "netural", or items 23s or 28s-f show ury or other tranmat to rectify also 10e State 10b. County 10c. City, Town or Location 10d, inside City Limits 1 ☐ Yas 2 No Director MD BALTIMORE ROSEDALE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 1220 HILLDALE Funeral 21237 12. Was Decadant Ever in U,S. Armed Forces? 1 ☐ Yas ②☐ No If Yes, Give Yeer or Detes: 14. Race - Amarican Indien. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, Whita, etc. 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: P WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grede completed) 16a. Decedent's Usuei Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamentery/Secondary (0-12) Collega (1-4or 5+) OWN HOME. Unk. Unk. HOMEMAKER 17. Fether's Neme (First, Middle, Last)
Unk. 18. Mother's Neme (First, Middle, Meiden Surneme) Be Unk. 2 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Wilburt C. Hughes / son 5731 Pine Country; San Antonio, TX 78247 20b. Pleca of Disposition (Neme of 20e. Mathod of Disposition Dete 20c. Location - City or Town, Stete cemetery, cremetory or other pleca) Gardens of Faith 1 Burial 2 Cremetion 3 Removal from Stata 4 Donetion 5 Other (Specify) 3-9-99 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Nama and Address of Fooility CVach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disaesa or condition resulting in deeth) ACUTE MYOCARDIAL INFARCTION 1 DAY Examiner Due to (or es e consequenca of): Examiner CORONARY ARTERY BYPASS GRAFT 2 YEARS physician and s the burial-transit that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) signed by the al Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE þ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy s certificate has b 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director. 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 26b. Tima of 26d. Describe how injury occurred Certification: 28c. Injury et Work? 1 2 Neturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 26e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 2 4 Homlcide To the Hospital or within 24 hours aft To the Funeral DI complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es stated.
2 Medicat Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end placa, and due to the ceuse(s) end menner steted. 29a. Certifier edical 29d. Dete signed (Month, Dev. Year) 29b. Signeture end title of certifier 29c. Licensa number D D.O. H35593 MARCH 8,1999 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) DR. JOHN J. LOH 1124 MACE AVENUE, BALTIMORE, MD.21221

31. Dete filed (Month, Day, Year)

62. Registrar's Signatura State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month HITCHO DOROTHY 2200 March 4 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□ M 2☑ F Months Days JAN 16 1918 MARYLAND 577-01-2596 10a. State 10b County 10c City Town or Location 10d. Inside City Limits Pasadena 1 ☐ Yes 2 ☑ No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 186 Lake Shore Drive 21122 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Ray Granville Jeffers Cantler 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Hitcho son Rt 3 Box 227 R Charles Town West Virginia 25414 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady of The Fields 3/8/99 4 ☐ Donation 5 ☐ Other (Specify) Millersville, MD 21. Signature of Funeral Service Licenti 22. Name and Address of Facility TALLINGS FUNERAL HUML F.A.

3111 Mountain Road Pasadena, MD 21122

The mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death STALLINGS FUNERAL HOME P.A. wohe Immediate Cause (Final DESMONIA disease or condition resulting in death) Due to (or as a consequence of): CANCER MOSTAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23h. Did tobacco use contribute to the cause of death? 1 No 2□ No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Examiner Examiner physician and the burial-trensit The law requires that the death certificate be executed Box 68760. Physician/Medical . 980 Division of Vital Records, P.O. the signed by t à Completed certificate or Attending Physicien: Be Certification: To this After n 24 hours after deeth.

Ne Funerel Director: Afte bletely filled in by the fun-Hospital

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

the state of

death

illed within 72 hours after of Hygiene. The "netural", or item then "netural", or item

permit. Pages 1 and 2 should be filed wh Department of Heelth and Mental Hyglent Important: If item 27 is marked other tha any injury or other traumatic event, that, page.

Physician /Medical

Baitimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

ANEMIA 14 PERTENSION 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month. Day Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 | Yes 2 | No 3 ☐ Suicide 6 ☐ Could not be

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of cartifier

29c. License number 29d. Date signed (Month, Day, Year)

D39037

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

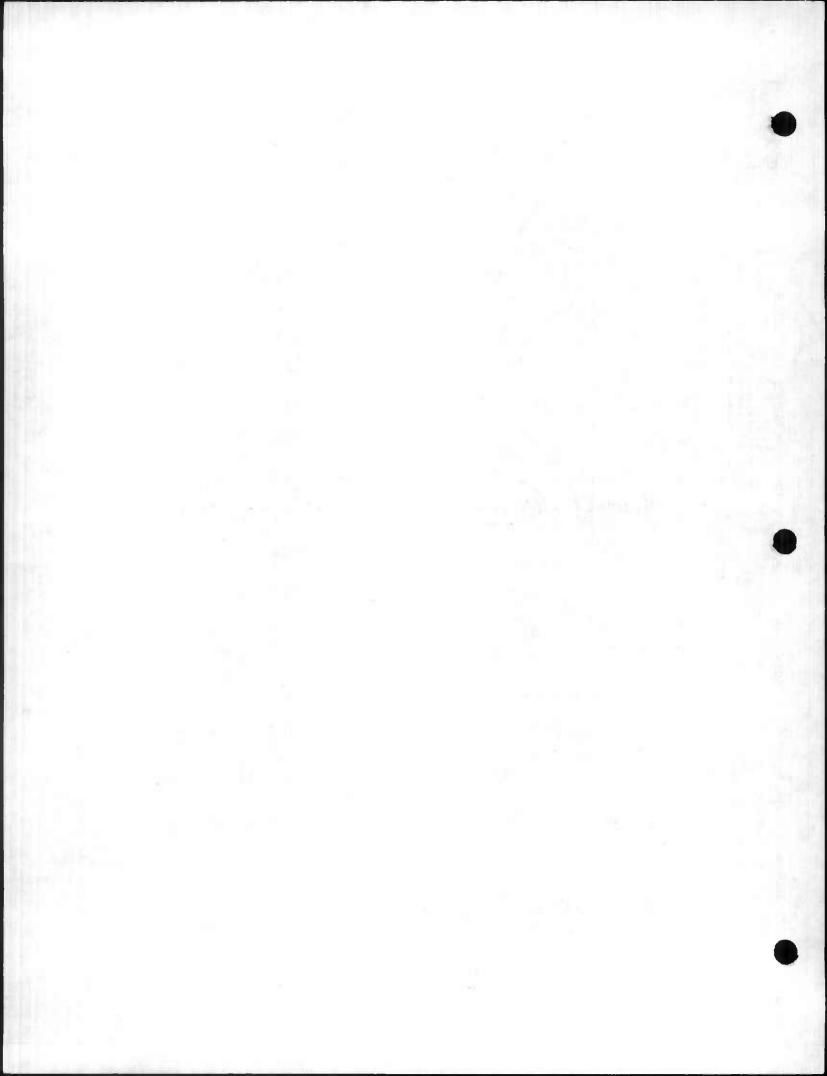
5 ANNE ARUSOEL MEDICAL CENTUR AUNDOCIS MD MITCHELL DOUGLAS 31. Date filed (Month, Day, Year)

State Registrar

edical



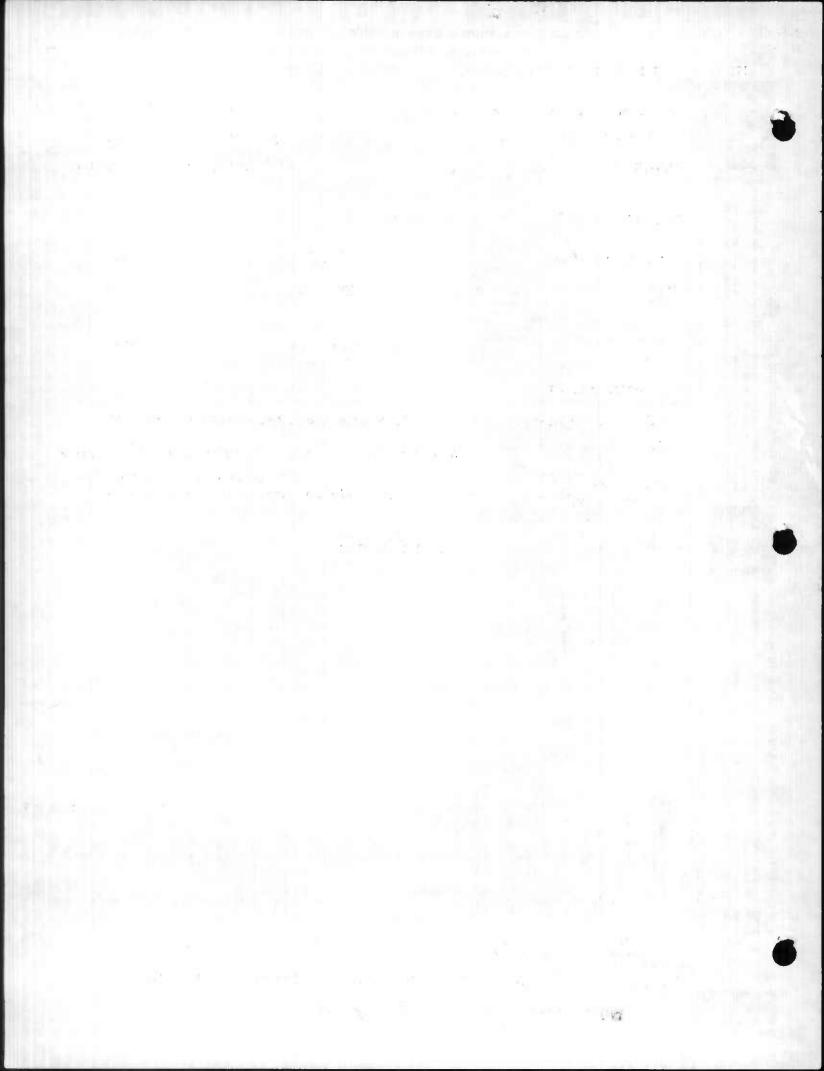
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

225-510 ITEMS: #	23 PART I, 27 PER MEO G	State of Maryla 3770 4-2-99 WR.		artment of I tificate of		Mental Hy	giene 9 9	071:17		
Physician /Medical	1. Decedent's Name (First, Middle, Last) Benjiamin Steadore Hoff III					2. Date of De Month MARCH	Day 3, 1999	Year 3. Time of Death		
Examiner	4a Fecility Neme (If not Institution, give street and number) 4b. City, Town, or to 1607 BURNWOOD ROAD BALTIMORE						E CITY NA			
Funeral Director		Sex 7. Age (In yr	zs. last birthday) Yrs.	If Under 1 Yeer Months Days		8. Date of Bi (Month, Pi Feb. 24	,1977	9. Birthplaca (State or Foreign Country) Maryland		
the Maryland 28a-f ahow cuff of a	10a. State 10b. County		City, Town or Lo				10d. Inside City Limits 1 → Yes 2 □ No			
death with the Manyland ms 23s or 28s-1 show times to notified at neral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of							/hat Country?		
020 urs after Mr, or its	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: Jucation 16a. Decede de completed) 16a. Decede (Give k Iffe. D		21225 . Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes XX No Specify: edent's Usual Occupation rekind of work done during most of working DO NOT use retired) ter/ Warehouse		pecify Yes or No pecify Yes or No pecify Yes or No	U.S. 14. Race Black Specify:	k, White, etc.		
	15. Decedent's E(Specify only highest gri					king	16b. Kind of Bu	siness/industry		
Marylarid 212: d2 should be filed within th and Mental Hygiene. 7 is merked other than traumatic avant, train To Be Comp	Benjiamin Hoff Jr	17. Fether's Name (First, Middle, Last) Benjiamin Hoff Jr. Florrette H						off		
other train	19a. Informant's Name/Relationship (April J. Hicks (si 20a. Method of Disposition 13. Burial 2 Cremation 3 C	Lster) 20b Removal from State	263 D. Placa of Dispo cametery, crem	88 Gate I sition (Name of natory or other ple		Baltime	ore, Md 2			
Baltimore, pemit. Pages 1 ar Department of Han Important: If han; any injury or other	4 Donation 5 Other (Specify) Arbutus Memorial Park 3/10/99 Arbutus 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Market							Funeral Home		
Physician Medical Examiner	23a. Part 1. Enter the discount or community of the commu	a	CARDIAC A	RRHYTHMIA	ing, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Deeth		
death certificate be assected death certificate be assected of for use as the burial-transit iclan/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a consequence (or es a consequence							
P.O. hat the d by the datache	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 44			
s been sign s been sign 2 should be							s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?		
= = # 2 0	25. Was case referred to medical		26. Place of Dea				1 1 No 1 No 1 No 1 No 2 No 1 No 1 No 2 No 2			
- 5 00	examiner? *CXYes 2 No 27. Manner of Death 1 Natural 2 Accident Investigation	Algorital: I Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing			ury at ork?	Home 5 ☐ Residenca M⊠Other (Specify) AT SC 28d. Describe how injury occurred				
To the Hospital or Attending Phywithin 24 hours after decided to the Funeral Directors. After this completaly filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)				28f. Location (Street and Number or Rural Route Numb City or Town, State)				
To the Hospital within 24 hours To the Funeral I completely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.									
To the comp	29b. Signeture end title of cartifier 29c. License number OCME 30. Name and address of person what completed cause of death (Item 23a) (Type, Print)						29d. Date signed (Month, Dey, Year) MARCH 4, 1999			
011	30. Name and address of person who Dennis J. 31. Date filed (Month, Day, Year)		Penn S	treet, B	altimore,	Maryla	nd 21201			
State Registrar		99 Benev		Spark	W					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Norris, Jr. March 7, John 1999 Henry 9:22 P.M. 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Deeth | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings | Ballings 643 Carroll Island Road Baltimore 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 1 X M 2 □ F Months Yrs. 220-18-9054 1926 Maryland 72 Usuel Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 643 Carroll Island Road U.S.A. 21220 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decadent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - Amarican Indian, 11 Marital Status Armed Forces: 1 X Yes 2 No If Yes, Give 12/1 Yaar or Detes: 17/15 Bleck, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade complated) Elamentery/Secondery (0-12) College (1-4or 5+) Car Carrier 12 Truck Driver 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middla, Last) John Henry Norris, Sr. Evelyn Horn 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 643 Carroll Island Road, Baltimore, Maryland 21220 Irene Norris (Wife) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Mathod of Disposition 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 3/11/99 Baltimore, Maryland Holly Hill Mem. Gardens 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Addrass of Fecility 21 Sign of re-of-Funeral Service Licenses Bruzdzinski Funeral HOme, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 enter the mode of dying, such as cardiac or respiretory errest, Approximate 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart feilure. List only one ceuse on each line. Intastation lung cana tmmediate Ceuse (Finel 3 Merile disaasa or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initieted events rasulting in death) Last Due to (or es e consequence of): Dua to (or as a consequanca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy 1 Tyes 2 No 1 TYes 2 No. 26. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Homa 5 🔀 Residence 6 ☐ Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examiner that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show solical Examiner must be notified at

Hygiene. other than "nature ent, the Western

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "n any injury or other treumatic event, the Menany injury or other treumatic event

Directo

Funeral

by

Completed

with the Merylend

deeth

72 hours efter

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital or Attending Physicien:

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Physician/Medical

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Completed

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Certification:

Medical

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25. Wes case referred to medical 1 Yas 2 No 27. Menner of Deeth 1 Netural 2 Accidant

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigetion 6 Could not be

28e. Date of Injury (Month, Dey Year) 28e. Pleca of Injury - At home, farm, straet, factory, offica building, etc. (Specify)

28b. Time of

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, and due to the cause(s) and manner as ateted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the tima, date end plece, end due to the cause(s) end mennar steted.

29b. Signeture end title of certifier

29c. License number

29d. Data signed (Month, Dev. Year)

your 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

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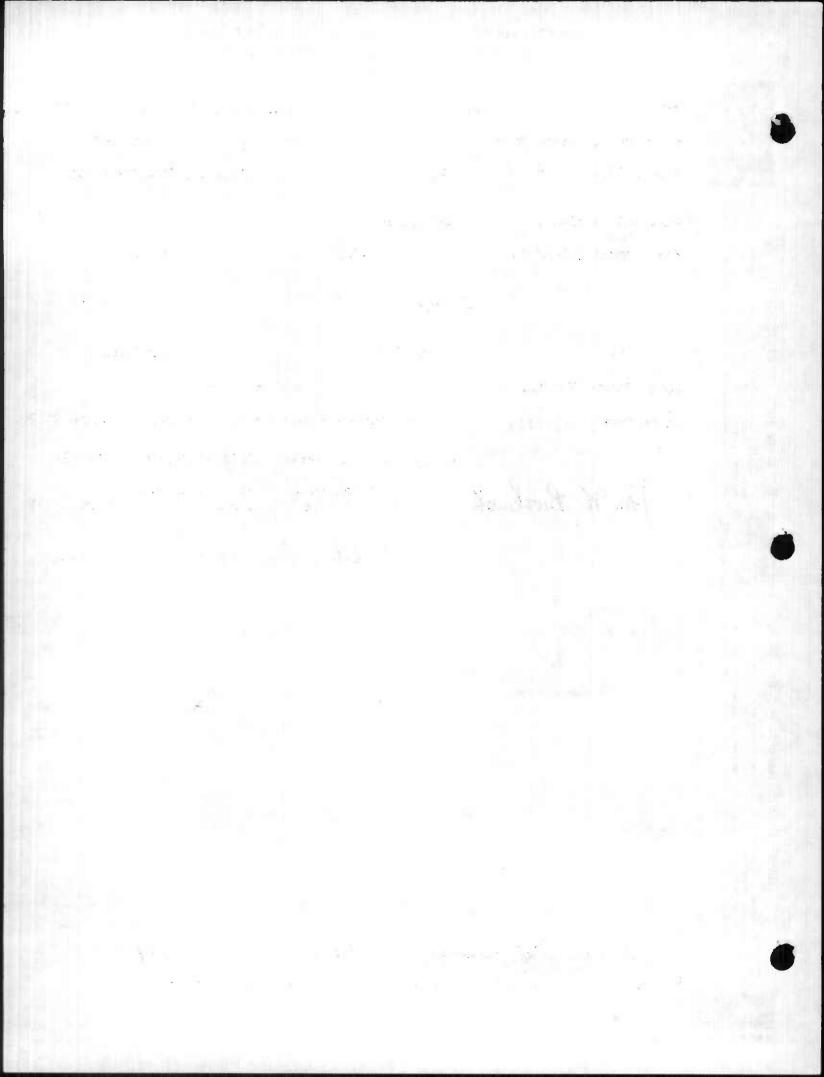
BALTIMOR Md 21224

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death MARCH 2 Day 1999 Year REBECCA INDICH 4:28PM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Data of Birth Month, Day, Year JAN 26 1903 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign Days Months Hours 1 M MX 215-03-7845 96 ROMANIA Yrs. Usual Rasidenca of Decedant 10b. County 10c. City, Town or Location 10d. toside City Limits BALTIMORE 1 Yas 2 No MD BALTIMORE 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4204 OLD MILFORD MILL ROAD 21208 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2 No Specify: SpeWHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Sepondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) YEHUDA KLEIN YETTA NEIGHER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zio Code) 15 FARMHOUSE COURT BALTIMORE, MD 21208 SYLVIA SCHONE/DAUGHTER 20a. Mathod of Disposition 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, Stata MIKRO KODESH BETH ISRAEL 3/4/99 1 Burial 2 Cramation 3 Ramoval from St BALTIMORE 5 Othar (Spec 4 Donation 22. Nama and Address of Facility SOL LEVINSON & BROS. INC 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only on a complication on each line. Approximata Intarval Batween Onset and Death Immediata Causa (Final diseasa or condition rasulting in daath) Neumonia Dua to (or as a consequence of) Dua to (or as a consequence of): Dua to (or as a consequence of):

Physician /Medical Examiner

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Division of Vital Records, P.O.

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Hygiene. other than "natural", or Itan ent, the Medical Examiner 72 hours after

permit. Pages 1 and 2 should be fitted within. Cepariment of Health and Mantal Hygiere, important: if Item 27 is marked other than 11 any Injury or other traumatic event, the Mad

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be edical Certification: To

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Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in daath) Last

was casa rara axaminar? 1 Yas 2 No

Manner of Death

Natural

2 Accidant

4 Homlcida

(Check only one)

29b. Signatura and titla of certifiar

3 Suicida

29a. Certifier

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify)

28b. Tima of

26. Place of Death (Check only ona)

28c. Injury at Work?

23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably Unknown

24b. Wara autopsy findings available prior to complation of causa of death?

1 ☐ Yas 2 ☐ No

Other Wursing Homa 5 Rasidanca 6 Othar (Specify)

2 No

28d. Describe how injury occurred 1 Yas 2 No

24a. Was an autopsy performed?

1 Yas

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

15 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

/Congrand

5 Pending invastigation

6 Could not be datarmined

29c. License number D4768

29d. Data signed (Month, Day, Year) 3 99

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

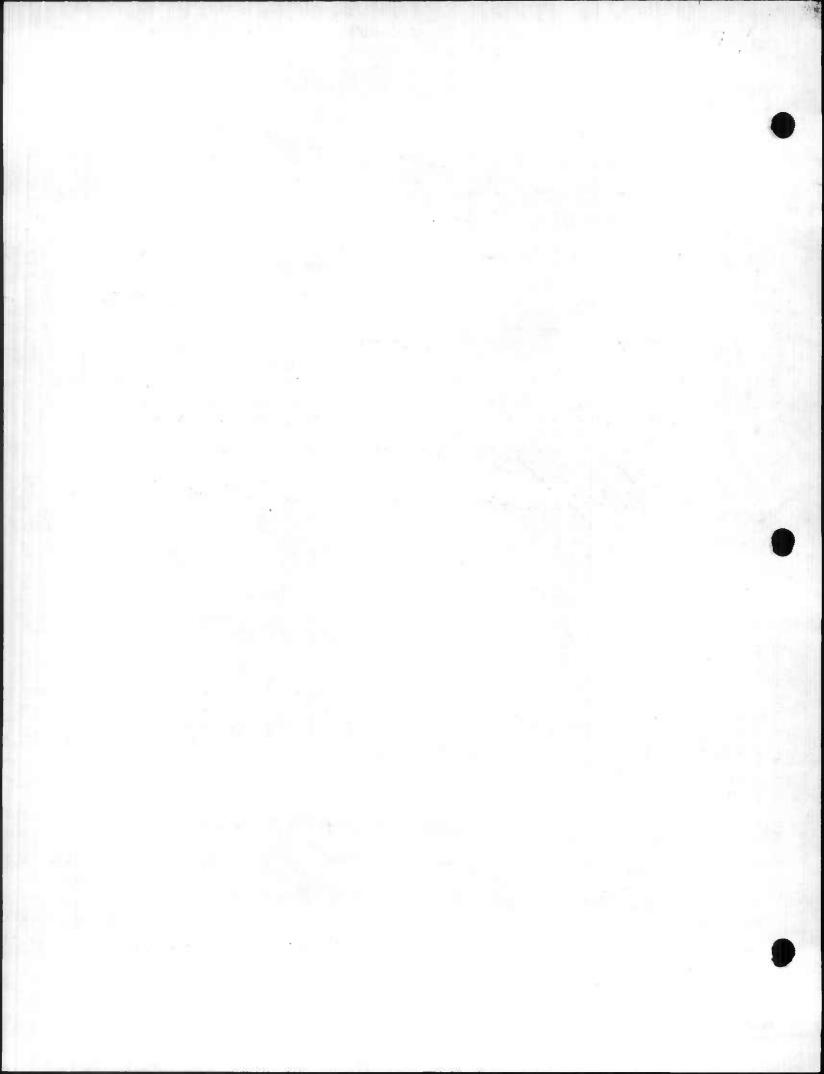
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31. Date filed (Month, Day, Year) MAR 9 32. Regist/ar's Signature

28a. Data of Injury (Month, Day Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Elmer Fillmore Ile 1999 March 05 9:20 PM /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 115 Cherry Hill Road Street Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** ₩ 2 □ F Months Days Hours Yrs. 215-16-6328 78 **Director** APR 20, 1920 Maryland Usual Residence of Decedent with the Maryland 10a Stata 10b Counts 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examinar must be notified at MD Harford 1 ☐ Yes 2 No Street Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21154 115 Cherry Hill Road USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 XYas 2 ☐ ₩₩ II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or item 1 Nevar Married 3 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Operator Heavy Construction 8 18. Mother's Name (First, Middle, Maidan Sumama) 17. Fathar's Name (First, Middle, Last) Jesse Ile Pearl Ewing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Olive H. Ile/wife 115 Cherry Hill Rd. Street, MD 21154 other 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 0 1 Bunal 2 Cremation 3 Removal from State Injury 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/08/99 Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Dawn F. McDonald Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 Dawn F. McDonald

299 Frederick Rd. Balti

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only ona causa on each line. Approximata Interval Between Onset and Death **Physician** GASTRIC ADENOCARCINOMA /Medical Immediata Causa (Final IS MONTHS disaase or condition resulting in death) **Examiner** Dua to (or as a consequence of) Examiner buriel-transit Sequentially list conditions, if any, leading to Immediata cause. Enter Underlying Causa (Diseasa or injury that initiated avants rasulting in death) Last end Due to (or as a consequance of): physician Physician/Medical the Dua to (or as a consequence of): attending for use es Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? the detech signed by d be detect 1 Tes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funaral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Placa of Daath (Check only ope) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical (Check only 29d. Data signed (Month, Day, Year)

NA ARCH 6, 199 29b. Signature 29c_Licansa number

State Registrar

31. Data filed (Month, Day, Year)

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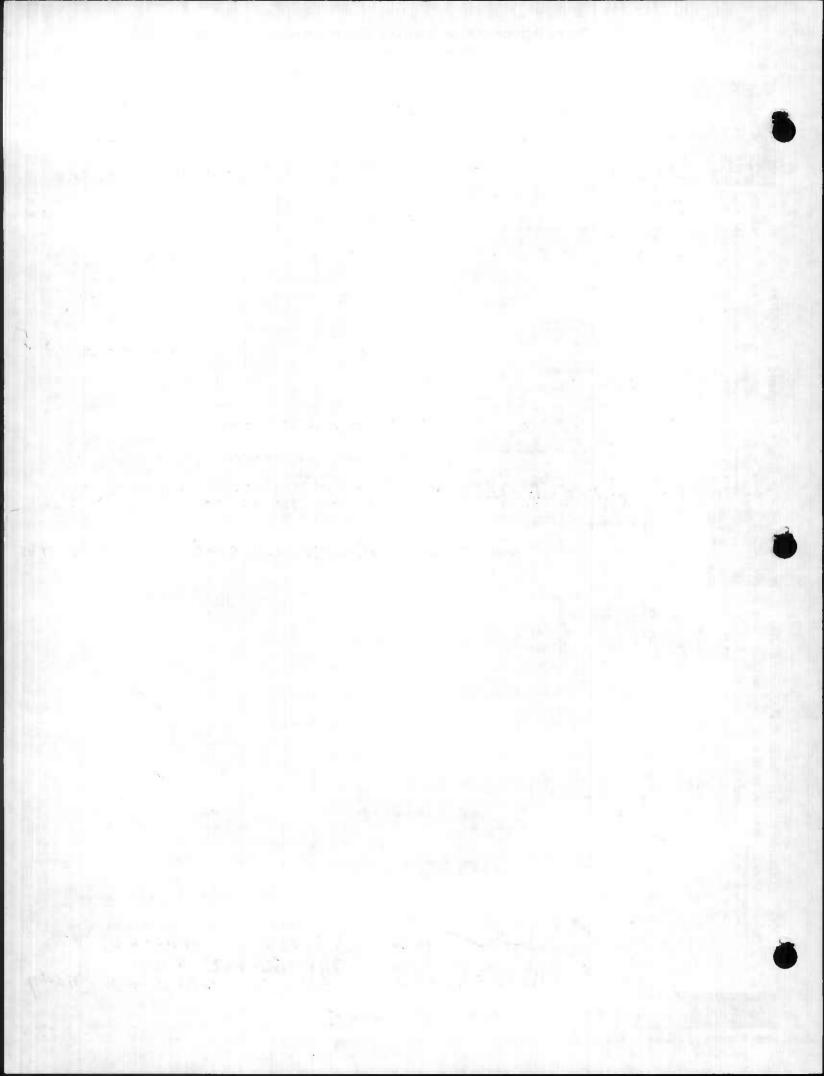
32 Registrar's Signatura

of death (Itam 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Month Kenneth George Johnson 6, March 11:18AM 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale Baltimore 8. Date of Birth (Month, Dey, Year) March 5, 1925 If Undar 24 Hrs. If Under 1 Year Birthpleca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Devs Months Hours 10 M 2□ F 215-16-1393 74 Maryland Usual Residence of Decedent 10d. Inaide City Limits 10a, State 10b. County 10c. City. Town or Location 1 Yaa 2 No Maryland Baltimore Baltimore. 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4322 East Joppa Road 21236 U.S.A. 12. Was Decedent Ever in U,S. Amped Forcas? 1 △ Yas 2 △ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerlo Rican, etc.) Race - Amarican Indian, Black, White, etc. 1 Navar Marriad 2 Married 1 Yes 2 No Specify: Specify: White 3 Nidowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Elamentary/Secondery (0-12) Collega (1-4or 5+) Pipe Fitter Oil Company 9th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Surneme) Haskell Johnson Sophie Ruth 19b. Mailing Address (Street end Number or Rurel Routs Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Andrea Trageser (niece) 7 Leslie Avenue, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph Church Cem. 3/10/99 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name end Address of Facility 21 Signature of Funeral Service Licenses Schimunek Funeral Home, Inc. 1400 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. Immediate Cause (Final diseese or condition resulting in death) Saquentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in daath) Last Due to (or es e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably # Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? trulu nephroga 24a. Was an autopsy 2 2000 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of

Physician /Medical **Examiner**

Physician

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Examiner

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29b. Signature and title of certifier

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1 Matural

2 Accident 3 Suicide

4 ☐ HomicIde

(Check only one)

29a. Certifier

29c. Licensa number 025-686

1 Yes 2 No

Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signad (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

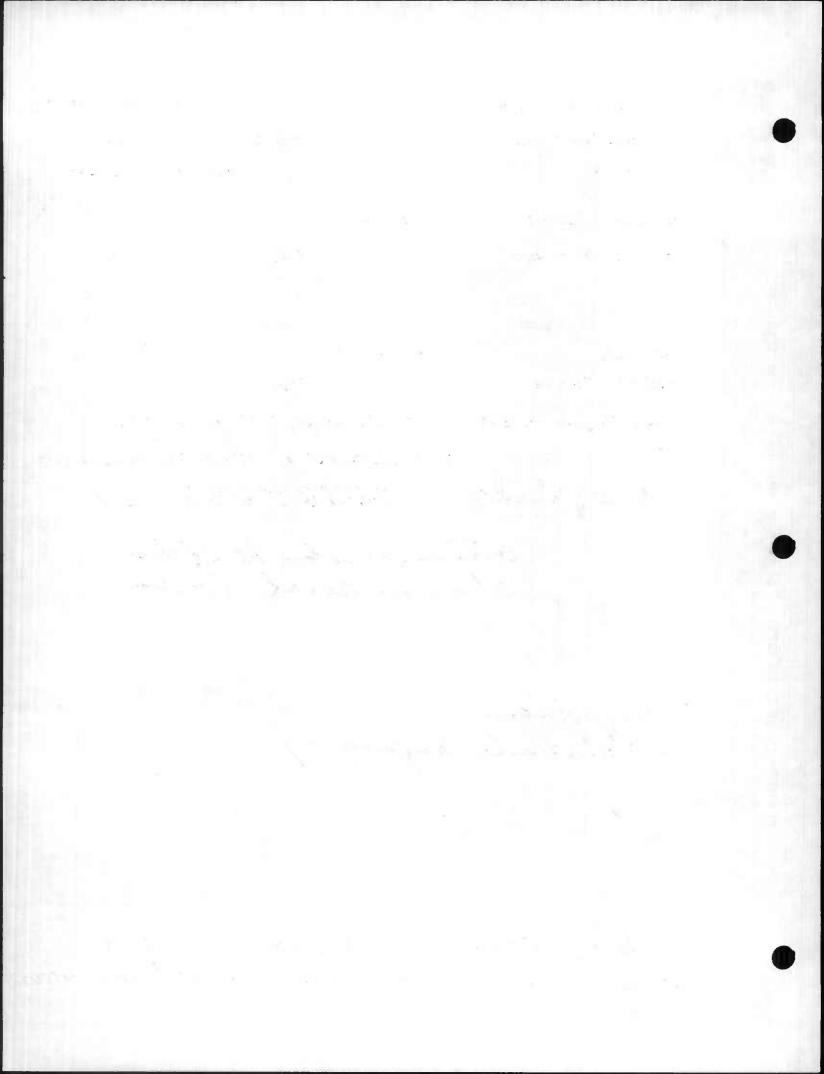
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

person who completed cause of death (Item 23a) (Type, Print)
IPAKEHI 7600 OSLER DRIVO SUITO 301 BATTMEN MOZIZON GBRAHIM 31. Date filed (Month, Day, Year)

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32 Registrer's Signature

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)



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State Registrar

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 0. MAUNG 31. Date filed (Month, Day, Year)

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29b. Signature and title of certifier

32. Registrar's Signature

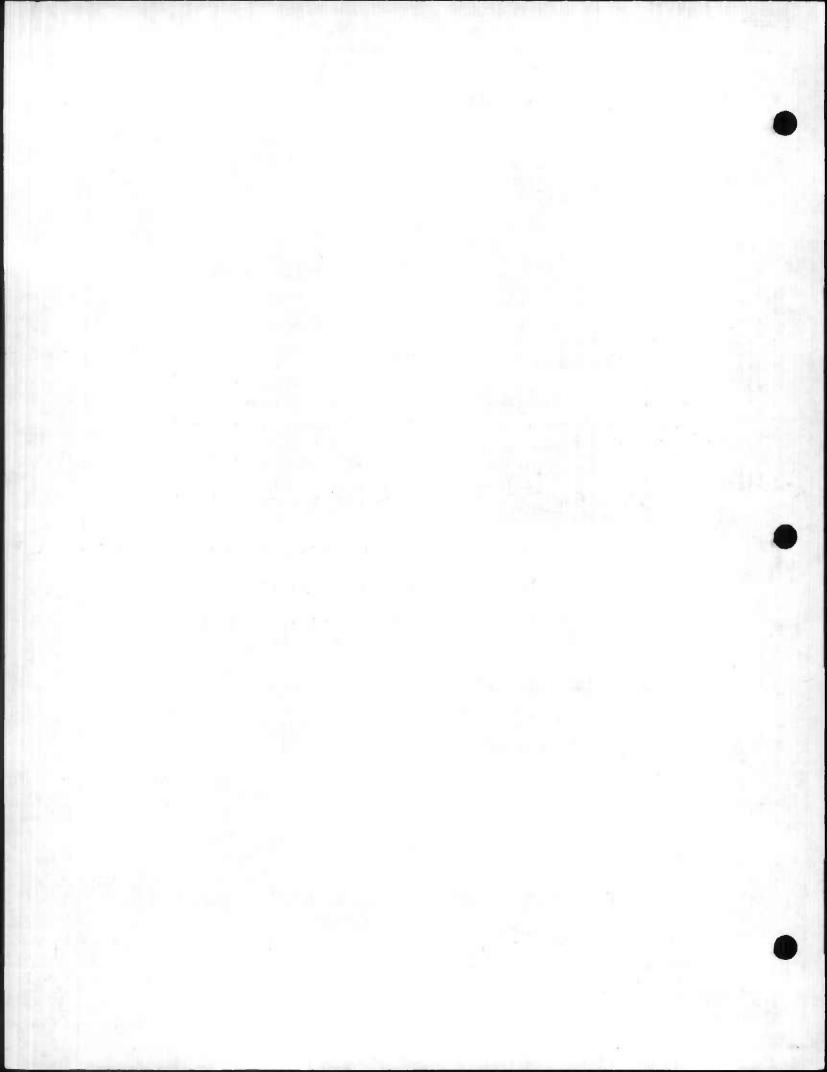
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12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

716 MATTER CHOICE LANG SUITE 300, CATONIVILLE IN D 21228

29d. Dete signed (Month, Day, Year)



Physician /Medical Examiner Examiner

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Division of Vital Records.

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25. Was case referred to medical

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No 27. Manner ot Death 1 Matural

5 Pending Investigation 6 Could not be determined

28c. tnjury at Work? 1 ☐ Yes 2 ☐ No 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

2 Accident

3 Sulcide

4 ☐ Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

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29c. License number 12381 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

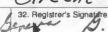
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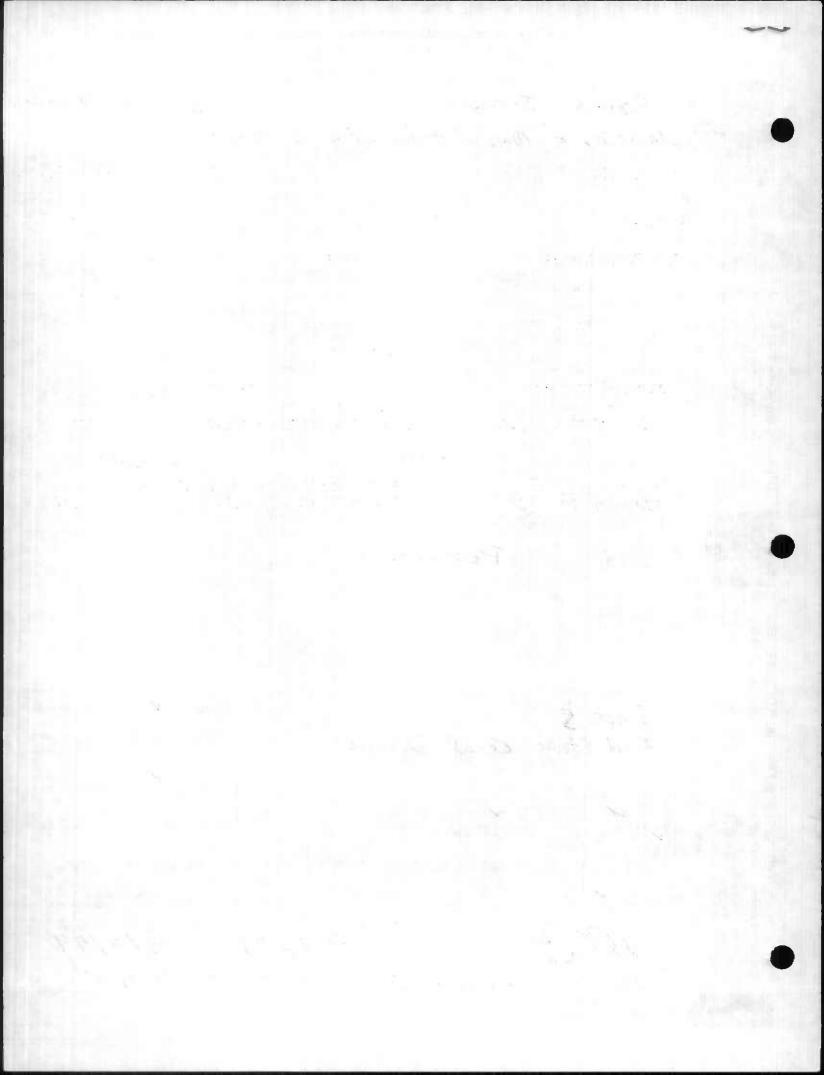
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permit. Pages 1 and 2 should be filled within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or frems 23a or 2 and highry or other traumatic event, the Medical Examiner must be an page.

Baltimore, Maryland 21215-0020

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25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth

26. Place of Death (Check only one) Hospitel: 12 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

1 Natural 2 ☐ Accident 3 ☐ Suicide 4 Homicide

28e. Date of Injury (Month, Dev Year) 5 Pending investigation 6 Could not be

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier

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2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end pieca, and due to the cause(s) and mannar stated.

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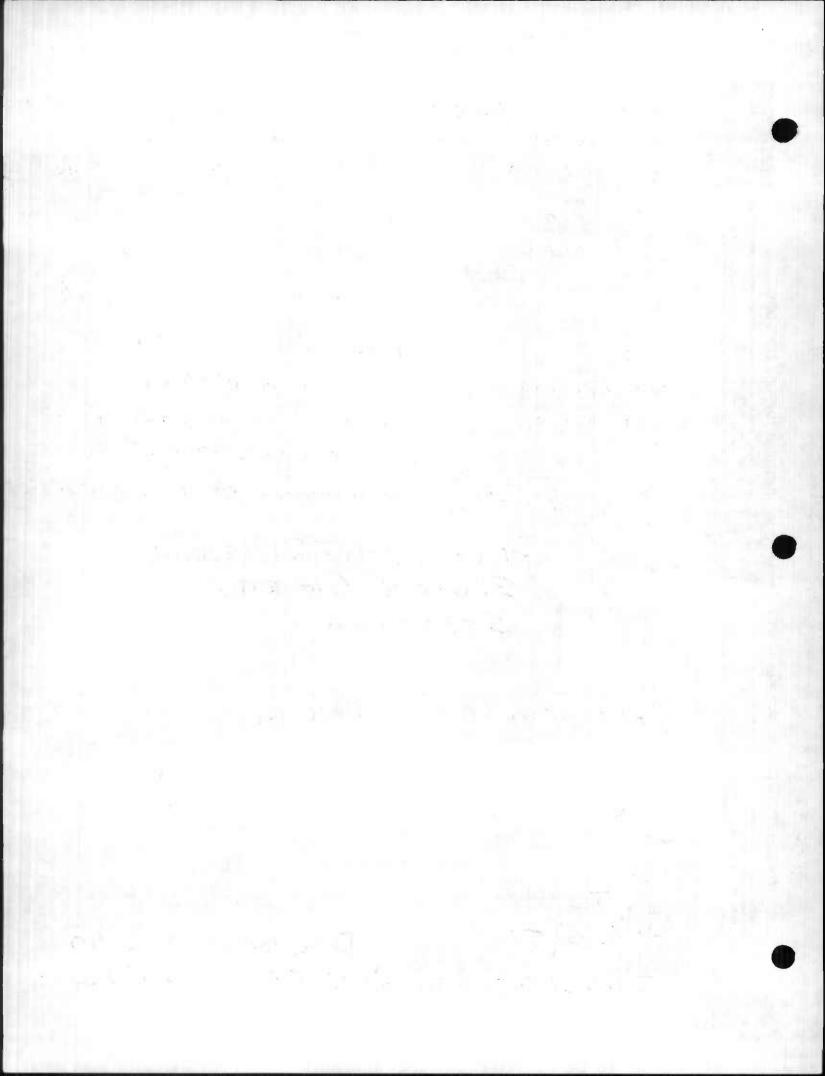
29c. Licansa number

29d. Data signad (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

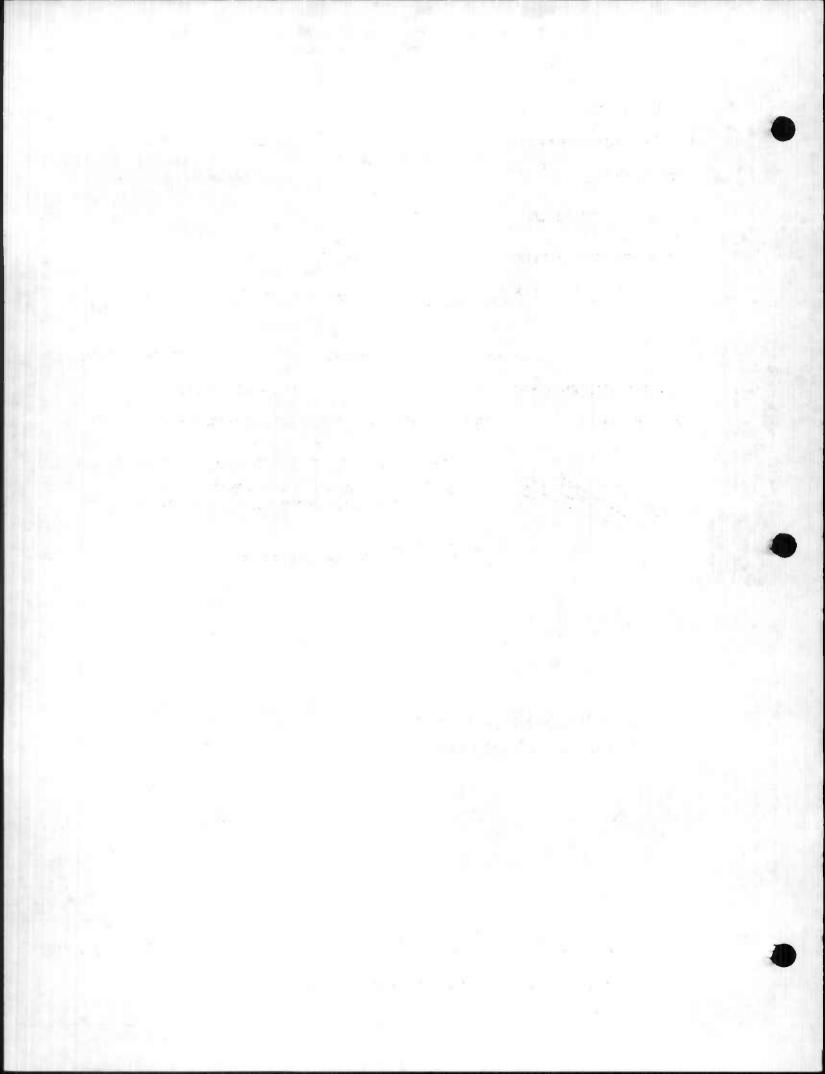
(ROAD, BALTIMORS. MD 21220 1999^{32. Registrer's Signeture}

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo

	Decedent's Name (First, Middle, Last)					of Death Reg. No. 2. Date of Death 3. Time				3. Time of Death	
Physician							Month	Day	Year		
/Medical	ERNEST	EDWARD (If not Institution, giv	JAMES	e)		4b. City, Town, or I	MARCH location of Deeth	8 19	999	6:45 A.M.	
Examiner				7)							
		NTWORTH A			I Killadar i Vaar	HILLENDA					
neral ector	5. Social Security 235–42–3 Usual Residence of	859	Sex 7. A 1X M 2□ F	Age (In yrs. last birt	hday) If Under 1 Year Months Days			Year)	9. Birthpl Count OHIO	ace (State or Foreign ry)	
al; or items 23a or 28a-f ahow Examiner must be notified at by Funeral Director	10a. Stete	10b. County		10c. City, Town	or Location				10	d. Inside City Limits	
ō	MD	BALTIM	IORE	HILL	ENDALE					1 ☐ Yes 2√ No	
Director	10g. Citizen of W								Vhat Count	trv?	
			TENTI IE		21234						
era	11. Marital Status	TWORTH AV	12. Was Deceder	nt Ever in U.S.	13. Was Decedent of I		pecify Yes or No-		SA a - America	an Indian,	
by Funeral	1 Never Mar	ried 2 Married	Armed Forces	37	It Yes, specify Cub	an, Mexican, Puert Specify:	o Rican, etc.)	Specify Specify			
		15. Decedent's E			Decedent's Usual Occup	nation		WHITE 16b. Kind of Business/Industry			
Completed	(Spe	cify only highest gr	ade completed) (Gi life College (1-4or 5+)		(Give kind of work done during most of working life. DO NOT use retired)		rking				
	17 Father's Name	(First, Middle, Last	2 YEARS SUPERVIS					POSTAL SERVICE Je, Meiden Sumeme)			
Be											
5		RICHARD J		101	Mailing Address (Ctross		LICE HENF		State 7in	Code	
To		lame/Reletionship (Mailing Address (Street						
	ROSE E.		WIE		757 WENTWOR Disposition (Name of	TH AVE.	BALTIMOR		2123		
	1 ☐ Burial 2	Cremation 3		cemeter	y, crematory or other ple	ce)	Date	20c. Location - City or		TOWIT, State	
		5 Other (Specif		METRO	CREMATORY,		/9/99	CATONSV	ILLE,	MD	
2008	21. Signature of F	uneral Sarvice Zice	1600		22. Name and Addre		I. HOME. I	Δ			
e 0	THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286										
cian dical diner	Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of):										
cian/Medical Examiner											
Icla	Part II Other elgo	I. Other significant conditions contributing to death but not resulting in the underlying cause					se given In Part I. 23b. Did tot			bacco use contribute to the cause of death?	
by Physician/M	Co	0 1					1 _ Yee			V	
Completed by P	Hyperclulesterolinia					24e. Was		n eutopsy ned?	600	ere autopsy findings eilable prior to appletion of cause death?	
Juc	V'						1 □ Ye	s 2 XNo		Yes 2□ No	
	25. Was case refe	erred to medical				06 Bla 5				1199 2 110	
is certificate director, pag To Be Co	exeminer?	No	Hospital:	tion 0 7 50/0	tration 25 Do. Ot	hor	ath (Check only on		as (0*	.1	
tlon: To	27. Manner of Dee	1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury								
Certification:	3 Suicide 4 Homicide	6 Could not be determined	e 28e. Place of I	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number City or Town, State)			l Route Number,	
edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.										
Medical Certifi	29c. License number 29d. Date signed (Month, Day, Year,							Day, Year)			
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		ress of person who		/		Ma					
	Brent P		600 Wolf		Baltimore,	Ma					
State Registrar	31. Dete tiled (Mo	R 9 1999		strar's Signature	for de	1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month 1030/Am Physician 1ASSIE Jones MARCH 1999 /Medical 4c. County of Deeth 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Medical Baltimore
If Under 1 Year | If Under 24 Hrs. 8 Center City 8. Dete of Birth (Month, Day, Year) / - 2 Z - Z Z Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Deys 220-22-7320 Usuel Residence of Decedent 1 M 2 P Yrs. **Director** 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f sho other traumstic event, the Wed cal Expresser must be notified at NA 1 Yes 2 No MD Director BALTIMORE 10e. Street end Number 10a. Citizen of Whet Country? USA 2121 avk Lake Funeral 12. Was Decedent Ever Armed Forces? Was Decedent of Hispanto Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Deles: 1 ☐ Neyer Merried 2 ☐ Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Black P 3 ₩idowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) Beautician NA 17. Father's Neme (First, Middle, Last) 18. Mother'e Name (First, Middle, Maiden Sumame) Be 2 should be fi end Mental H Is marked off Richardson Frank 19a. Informent's Neme/Reletionship (Type, Print). Prienel 19b. Malling Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 2 st Department of Health end Important: If item 27 Is in 20b. Pleca of Disposition (Name of camelery, crematory or other place) ROOKS BALTIMON, MDZ1216 LENG m. 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State ò Cewitery 3 4 ☐ Donetion 5 ☐ Other (Specify) any injury 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility WYLie BALTimure ND. 2/2/ Approximate Interval Between Onset end Deeth Gilwor 23a. PeAt. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. **Physician** Cerebral Infarction /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Cardiovascular disease Atheroscleroti Examiner physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): usa as i Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown VASCULAN disease. 24b. Were eutopsy findings aveileble prior to completion of cause of death? hypertension hypothyxoidism 24e. Wes en eutopsy performed? 1 Yes 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer?

1 Yes 2 No Be 26. Plece of Deeth (Check only one) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27 Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Aftar 1 Naturel
2 Accident 5 Pending Investigation 24 hours efter death. 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

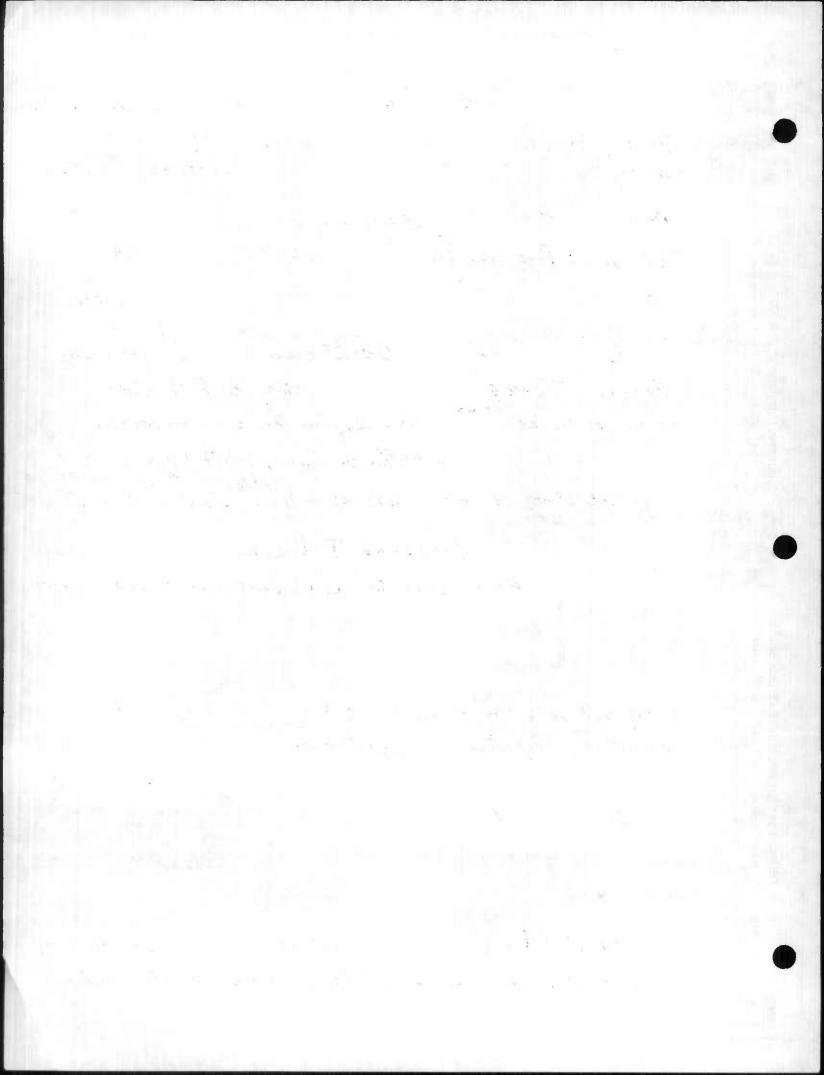
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature end title of cartifier 29d. Date signed (Month, Day, Year) MARCH 30. Name and eddress of person who completed cause of deeth (Item 23e) (Typ., Print) Place

32! Registrer's Signature

Baltimere MD

21202

State Registrar

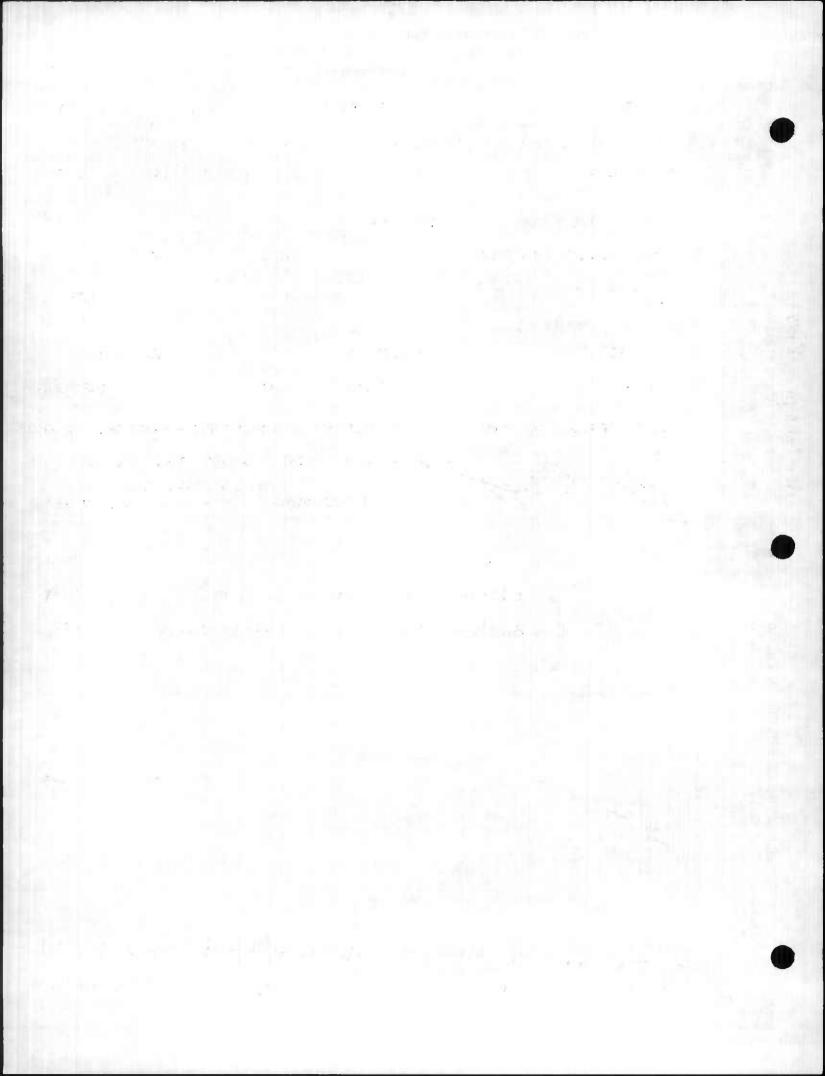


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State of Maryland / Department of Health and Mental Hygiene 0 071, 27

	Certificate of Death Reg. No.									
Di di di	Decedent's Name (First, Middle, Last)	2. Data of Death	Month Day Year I							
Physician /Medical	FINIA	MARCH	3 1999 1420							
Examiner	at the state of Double of									
		Himore City	N/A							
Funeral Director	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Undar 1 Year If Undar 2 Months Days Hours	Min. 8. Date of Birth (Month, Day, Ye MAY 9, 19	9. Birthplaca (State or Foreign Country) RUSSIA							
9	Usual Residence of Decedent									
nylen Mow	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits							
ith the Merylen or 28a-f ahow e notified	MD BALTIMORE BALTIMORE		1 □ Yes XX No							
deeth with the Meryland rms 23a or 28s-f show rmust be notified at	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country									
\$ 23 a	6944 MILBROOK PARK DRIVE #2C 212	215	RUSSIA							
020 urs after al', or the	3 Wildowed 4 □ Divorced If Yes, Give Year or Dates:	gin? (Specify Yas or No- l, Puerto Ricen, etc.)	14. Race - American indian, Black, White, etc. Specify: WHTTE							
1215-002 within 72 hours no. han "netural",	15. Decedent's Education 16a. Decedent's Usual Occupation	. Kind of Business/Industry								
T 5 1	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	r or working								
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Maryland nd 2 should be file ith end Mental Hy 27 is marked oth traumatic event	MOGILEVSKIY MAL	YA	(UNKNOWN)							
laryla 2 should end Men is marke aumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	er or Rural Route Number, Ci	ity or Town, State, Zip Code)							
imore, N Pages 1 end nent of Health ant: If Nem 27 ury or other to	ELLA SHEYMAN / DAUGHTER 20a. Method of Disposition 1 Description Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6944 MILBROOK PARK DRIVE #2C - BALTIMORE, MD 2121 20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO 3/4/99 BALTIMORE, MD									
Baltim permit. Pa Departmen Important: any Injury.	21. Signatural of Emberal Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC.									
	8900 REISTERSTOWN ROAD - PIKESVILLE, M									
1000	Approximate shock, or heart failure. List only one cause on each line. Approximate interval Betwee Onset and Deal									
Physician										
/Medical	Immediate Cause (Final disease or condition a. SEP5 \(\)									
Examiner	Due to (or as a consequence of):									
P # 5	- Bilateral lower extremity i	schemia	1 day							
60, be exacuted ician and bunal-transit	Sequentially list conditions, Due to (or as a consequence of):									
68760, ificate be exerging physician a as the burial-ledical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Bilateral bower extremity is chemistry is chemistry is chemistry in the initiated events b. Bilateral bower extremity is chemistry is chemistry in the consequence of the consequence									
the stee	ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last C. B. LA teal Commad Clear the Rom 6us Due to (or as a consequence of):									
X 6										
Box eath cert attendin for use										
vision of Vital Records, P.O. Box Attending Physician: The law requires thet the death cent of death. •ctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use iffication: To Be Completed by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i	. 23b. Did toba	Did tobacco use contribute to the cause of death							
P.O. the the de by the a detached		1 □ Yes	2 No 3 Probably 4 Unknow							
Division of Vital Records, P.O. Box to attending Physician: The law requires that the death cer alter death settled: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use entitication: To Be Completed by Physician A.			Oth Man outensy findings							
cord v requir been s should		24a. Was an a performed	24b. Were autopsy findings available prior to completion of cause							
Rec has by ye 2 st			of death?							
f Vital Re yelclen: The last scentificate he director, page		1 ☐ Yes	20 No 1 Yas 20 No							
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hysici hysici his cer il direc	25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
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ion rath.: After e funer	1 □ Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No									
Divisio or Attendi after death. Director: A d in by the fi	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State)									
din partie	bullottig, etc. (Specify)									
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After I completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) Check									
within of the one of t	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
F 3 F 8	A52402321/A40/8666 MARCH 3, 1999									
		1 4000	ווואניו ליווא							
	T30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	raital at	BAltimore							
	GRIFFIN L. Dalis SINAI FIT	ospital of	BITTIMOIL							
State										
Registrar	MAR 9 1999									

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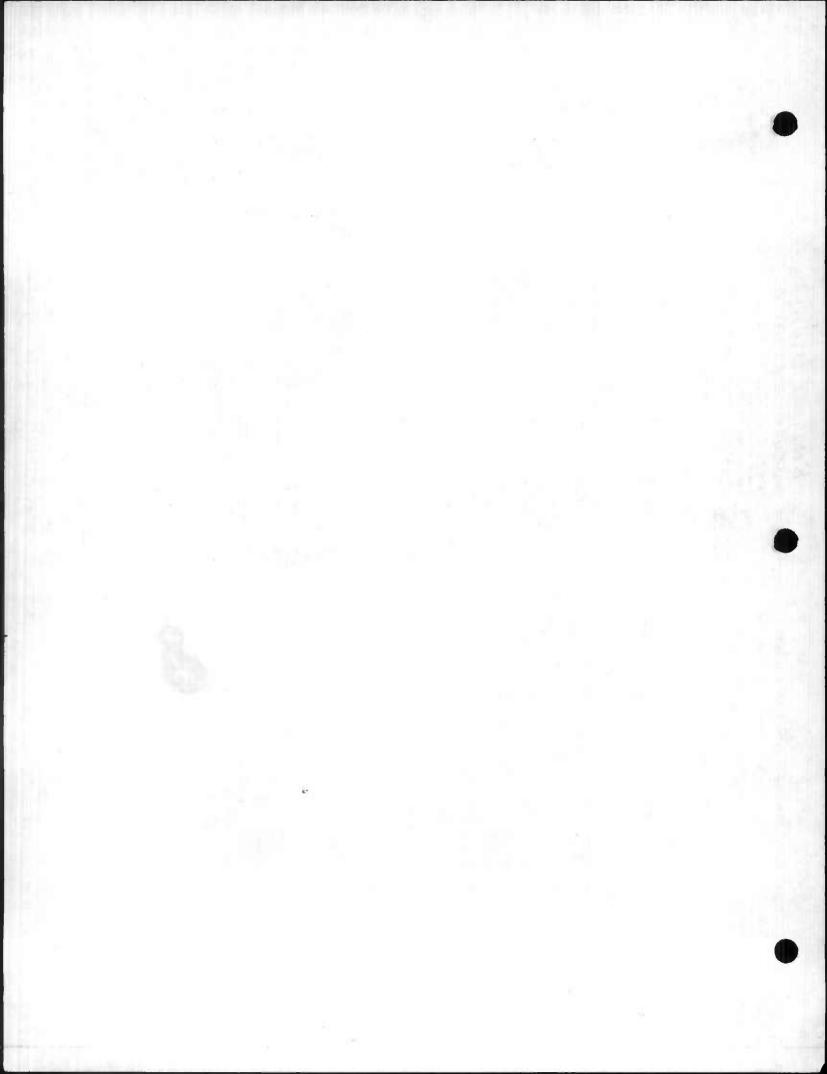


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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Edward R. King ARCh /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City N/A Stella Maris at Mercy If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs, last birthday) Birthplaca (State or Foreign Country) **Funeral** Days XXM 2□F Months 90 215-03-4897 Director Nov. 29, 1908 MD Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A Baltimore City MD NYas 2 No Director 28a-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b 1228 Hull Street 21230 United States Berns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married "natural", or 1 ☐ Yes Portion Specify: Specify: White þ 3 kg Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygisne. Longshoreman Shipping 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) Department of Health and Mental important: If Item 27 is marked or Shaw John Henry King (Unknown First Name) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Helene A. King / Daughter In-Law 809 Riverside Drive Pasadena Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 12 Burial 2 ☐ Cremation 3 ☐ Removal from Stata March 9,1999 Baltimore Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Nama and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Batween Onset and Deeth Physician Immediate Causa (Final disease or condition rasulting in death) /Medical Examiner Examine physician and s the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): the death certificate be execu Box 68760 Physician/Medical Due to (or as a consequence of): 080 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ Completed 24a. Was an autopsy performed? 24b. Wara autopsy lindings available prior to completion of cause of deeth? 25 No 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes case referred to medical axaminar? 26. Place of Deeth (Check only one) STELLA AT MERCY B MARIS Other: 4 Nursing Home 5 Residence 6 Mothar (Specify) #05 Pr 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? or Attending Fatter death. After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D edical Certifying Physician: To the best of my knowledge, death occurred et the tima, date and place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print) BAHIMORE ER9 31. Data liled (Month, Day, Year) 32 Registrar's Signatura State MAR 0 9 Registrar

ORIGINAL



Box 68760 Division of Vital Records, P.O.

physician and s the burial-transit that the death certificate be executed attending ph for usa as t signed by the a d be detached t should should aw certificate has b Attanding Physician: director, this funeral death. aftar deat Director: ò To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

Funeral

Director

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7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be

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1 and 2 should be Health and Mental

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Item

Physician /Medical

Examiner

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ltimore, Maryland 21215-0020

MARCH

EUGENIA KREBS

State Registrar

31. Dete filed (Month, Day, Year) MAR 0 9 1999

29b. Signafure and title of certifier

Laurence

R. Gallager MD 716 32. Registrar's Signature

Jamener Rfallager, 100

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

29c. License number

Maiden Choice home

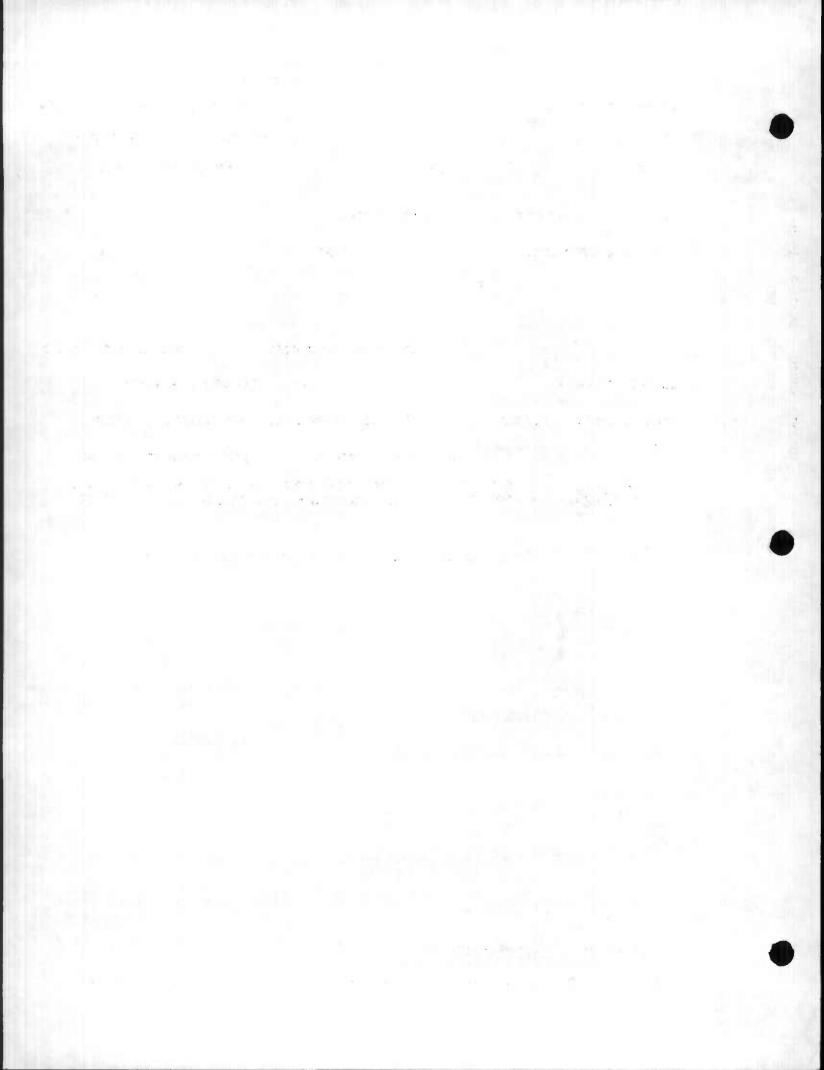
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29d. Date signed (Month, Dey, Year)

March 08, 1999

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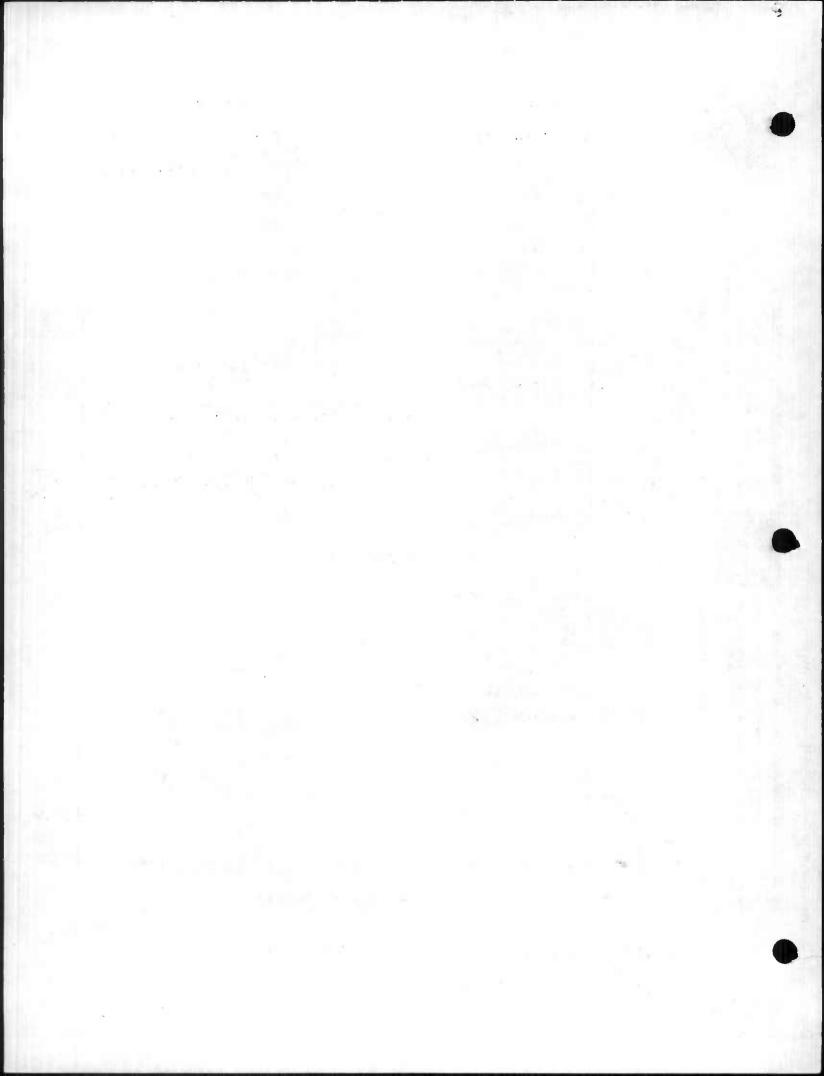
State Registrar 31. Dete filed (Month, Day, Year)

MAR 9

3/10/99

Frances Knight

32, Registrar's Signature

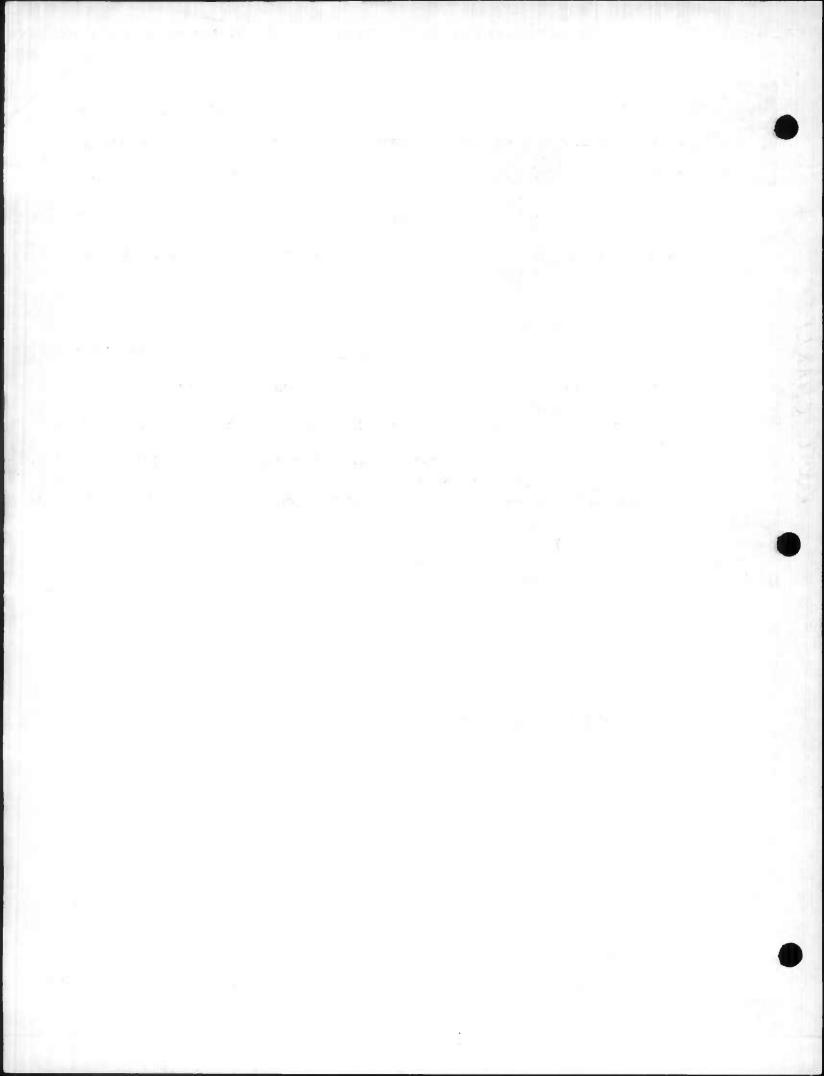


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State of Maryland / Department of Health and Mental Hygiene

Physician (Andread Examiner Andread Exam				Certificate o	f Death	Re	g. No.	074	0 1	
March Charles Charle							3. Time of Death			
GREATER BALTIMORE MEDICAL CENTER 5. Social Security Number 6. Social Secu		Charles L.	M			1.575	3:30PM			
Social Security Number 233-12-6424 100 x 217	2111111161									
213-12-6424 10								TIMORE	E	
Doc. State 100. County 100. Chy. Town of Location 101. Zip Code 102. Citizen of What Country? 100. Street and Number 101. Zip Code 102. Citizen of What Country? 102. Was Depoted of Every in U.S. 12. Was Dep	tor	213-12-6424		Months Doy	ar If Under 24 Hrs. s Hours Min.	8. Date of Birth (Month, Dey, June 23,	1922	9. Birthplece Country) Mar	(Stete or Foreign yland	
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1 (ABunel 2 Cremetion 3 (Bremovel from State Abunel 2 Cremetion 3 (Bremovel from State Abunel 2 Canapp 22. Name and Address of Facility 5305 Harford	by Fun	1 Never Merried 2 Married	1 ☐ Yes 2 ☐ No	1/		ican, etc.)	Bled	ck, White, etc.		
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Solution 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year	Σ :	29b. Signeture end title of certifier				d (Month, Dey,	Year)			
Jul S. Lale MD D39116 3/1/99		Juls. L	D39	39116 31719			99			
30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)			completed cause of deeth (Item	23e) (Type, Print)	il sur c				208	
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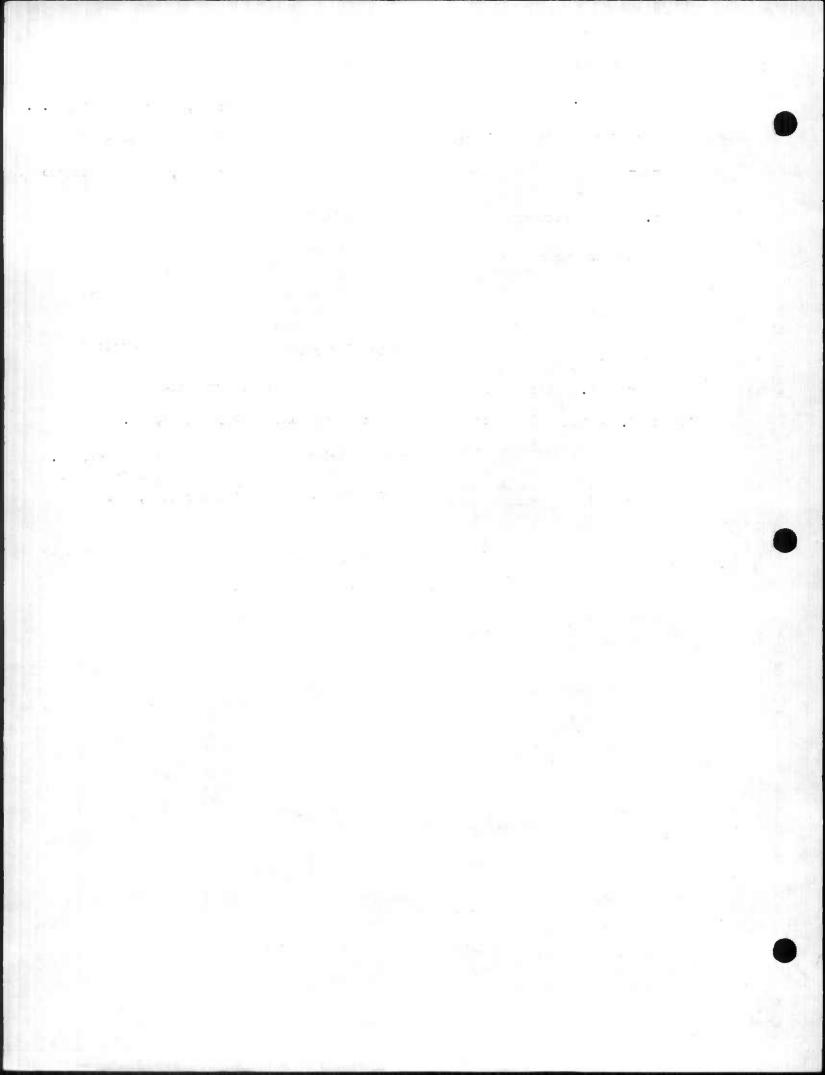
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Item 20b Per FH Film G769 3012088 rja Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dale of Death 3. Time of Death Month **Physician** VIOLA D. KELLER March 8, 1999 5:15 A.M. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Cherrywood Manor Baltimore Reisterstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days 85 215-26-7931 Yrs. Director April 26,1913 Reisterstown, Mc Usual Residence of Decedent the Maryland 10a. Stete 10b. County r 28a-f show 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Owings Mills 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ma 23a or 14 Wengate 21117 Road Funeral 12. Wes Decedenl Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Detes: Herna Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Stetus r than "natural", or flar the Medical Examiner Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: White py ¾XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Service State of Maryland 7th Grade Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be marked Mabel Triplett George R. Hunt 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) If of Health at It are or other tree (Daughter) 122 Nicodemus Road Reisterstown, Md. 21136 Joyce C. Fowble 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3-12-99 Department of Important: If any injury or Evergreen Memorial Finksburg, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Md. 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervst Between Onset and Deeth Physician /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner CONONAN ician and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Dertension Physician/Medical the 60 65 USB signed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings evailable prior to 24a. Wes en autopsy performed? completion of cause of death? page 2 t 🗆 Yes No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 24 hours after deeth.

Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner at the cause (s). Medical 29a. Certifier completely (Check only one) within 2 \$ 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 03-08-99 27075 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) Painters Mill RI \$126 O, Mills MD land's 90 31. Date filed (Month, Day, Year) MAR 0 9 1999 32. Registrar's Signature State Registrar



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		M T	Sto	MD	Anne Ar
		or 28a-	ě	10e. Street and Nu	mber
		emit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland peratment of Health and Mentel Hygiene. Incortant: If from 27 is marked other than "natural", or from 23e or 28a-f show my hjury or other traumatic event, the Medical Example.	To Be Completed by Funeral Director	7950 Tra	afalgar Cou
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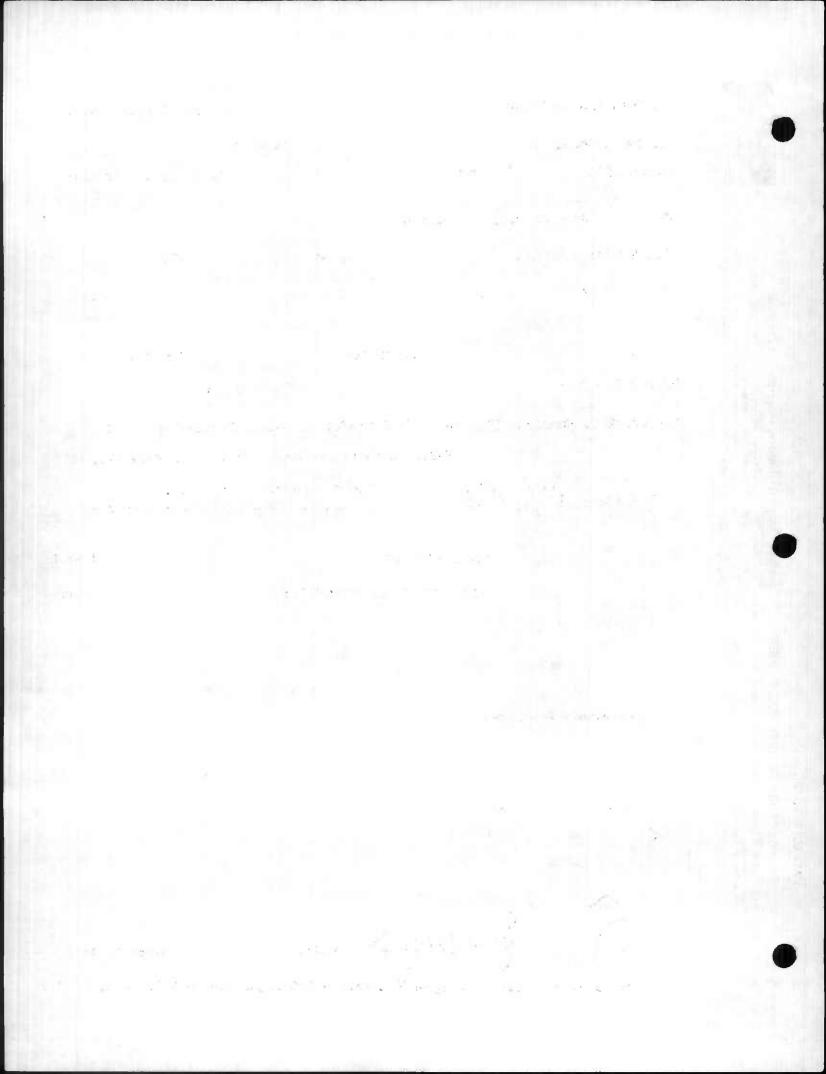
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Funeral Director

			Ce	rtificate o	, Douti.	1	Reg. No.	
1. Decedent's Nama (First, Middla, L						2. Deta of D Month	Day	Year 3. Tima of Death
Patricia Ann Kul	hblank					Mar		99 4:50 PM
4a Facility Nema (If not institution, g	ive street and n	umber)			4b. City, Town,	or Location of Dea	4c. County	of Death
St. Agnes Hospi	tal				Balti	more		
5. Social Security Number 6. 578–46–2290	Sex 1□M 2∏ F	7. Aga (fn yrs.	. last birthday) Yrs.	Months Dey	ar If Undar 24 h	lin. 8. Data of B (Month, E	irth Day, Year) 17,1935	Birthplaca (State or Foreign Country) Virginia
Usual Rasidance of Decedent								
10e. Slete 10b. County		10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limit
MD Anne	Arundel	L Se	evern					1 ☐ Yes 2½ N
10e. Street and Number				10f. Zip Code	9		10g. Citizan of	Whet Country?
7950 Trafalgar (Court			211	44		USA	
11. Marital Status	12. Was Dad	cedant Ever in L	J,S. 13.		of Hispenic Origin? uban, Maxicen, Pu	(Specify Yas or N		ce - American Indian,
1 Navar Marriad 2 Married 3 Widowad 4 Divorced	Armed F 1 Yas If Yas, G Yaer or I	2 No		1 Yas 2 N		iarto Hican, etc.)	Specif	ck, White, atc. y: White
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Harold R. Cross						Wheeler		
	(Time Brief)		10b Maili	ing Addrage /Stre	eet and Number or		her City or Town	State Zin Code)
19a. Informant's Name/Ralationship								
Frederick C. Kul	norank (Husband	1	O Trafa:	lgar Cou	rt, Seve.	rn, MD 2	1144 - City or Town, Stata
20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 4 □ Donation 5 □ Othar (Spec			camatary, cra	Matory of other p	olace)	03/10		ville, MD
21. Signature of Funeral Service Lic			2	2. Name and Add	drass of Facility			
	and the ations about	anunad Baldan	oth Do not on	12 Rido	gely Ave	nue, Ann	apolis,	MD 21401
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DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Items: 28a-f per M.D G-769 3/1 State of Maryland / Department of Health and Mental Hygiene Item 24,25,26,27.29 Per PHY Film G769 3-9-99 rja Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Desth **Physician JEANETTE** LEVIN G. 1999 MARCH 1, 11:50 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING HOME POTOMAC MONTGOMERY If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) DEC 28, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M aX F Months Days Hours 220-14-5185 91 1907 Director MD Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 No 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 급 7211 BROOKCREST WAY #2 21208 U.S.A. death Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes ② No
If Yes, Give
Yeer or Dates: |teme Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after WNever Merried 2 Merried 21215-0020 'natural', or 1 Yes 2 No Specify: WHITE Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 TELEPHONE OPERATOR AUTO AGENCY altimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Msiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental TSAAC LEVIN A. RACHEL GOODMAN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stste, Zip Code) . If item 27 JEROME SANDY / NEPHEW 5411 GALENA PLACE, N.W. - WASHINGTON, DC 20016 20b. Plece of Disposition (Name of cemetery, cremetory or other pisce) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete Department of Important; If any injury or once. BNAI ISRAEL CEMETERY 3/3/99 BALTIMORE, MD op 5 Dether (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. eral Service Licen 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 used the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finst TROKE diseese or condition resulting in desth) Examiner Due to (or es e consequence of): Examiner 308DURAL HERUATONA Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or trijury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the burial Box 68760. DRHEWMA Physician/Medical Due to (or es e consequence of) AVZHER INFORS P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. 50 à Completed 24b. Were sutopsy tindings available prior to 24s. Wes en eutopsy performed? completion of cause of deeth? page 2 1□ Yes ŽŪNo 2 No of Vital Be 25. Wes case reterred to medicat 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes X2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? P Division Attending 1 Neturel 5 Pending deeth. 1 ☐ Yes 2 No investigation 2/28/99 XX Accident 8:00 Patient Fell after deeth Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide ò filled in 1 Nursing Home Manor Care Nursing Home 24 hours r Hospital as: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

On the basis of exaministion end/or investigation, in my opinion, desth occurred at the time, date end placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one)

State Registrar

ANUSHIRAUM 31. Date tiled (Month, Day, Year) MAR 9 1999

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signeture and title of certifie

, SO, 13219 PEXREDIUS PARK TRARARS, GREAKINGUN 4820874 DADCOMO 32, Registrer's Signeture

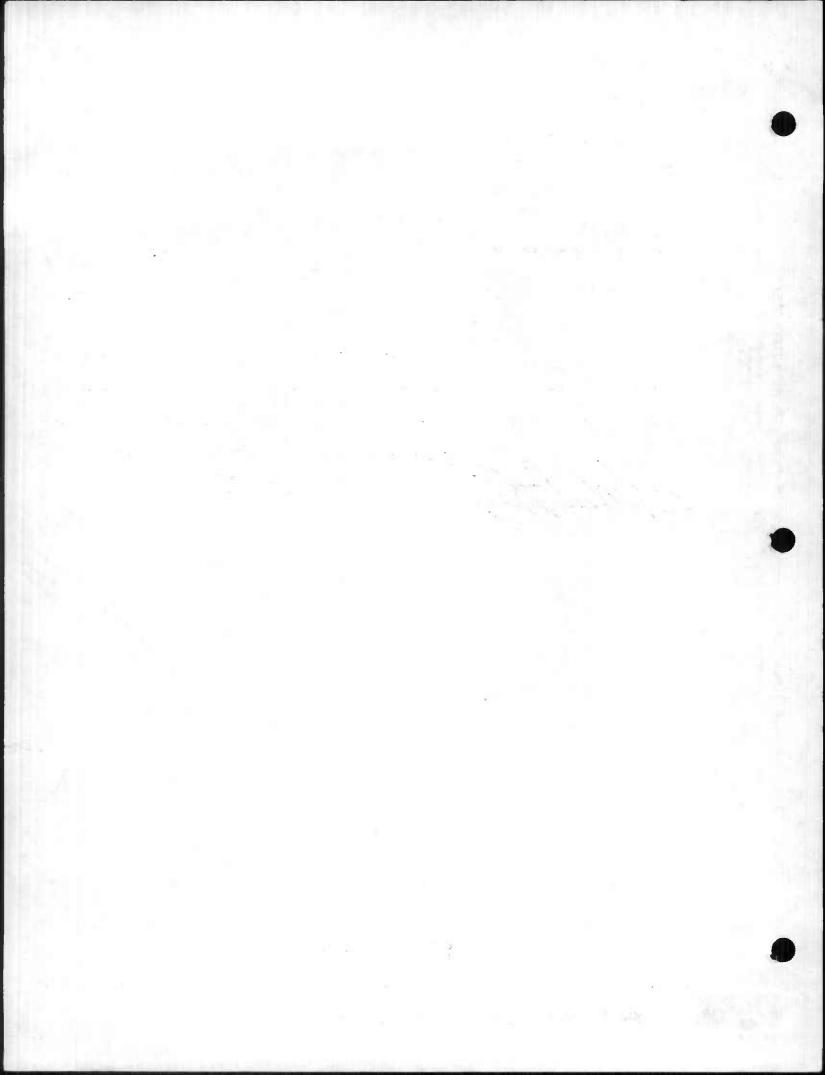
29c. License number

H51280

29d. Date signed (Month, Dey, Year)

3-2-99

within 2 To the å ‡



DANIEL LEVINE

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene

Of Ivial ylatiu /	Department of Health at
	Certificate of Death

Yrs.

Physician /Medical Examiner

Daniel Eric Levin

1. Decedent's Name (First, Middle, Last)

MARCH

2. Date of Death

7,

June 10, 1975

3. Time of Death

10d. Inside City Limits

4a Facility Name (If not institution, give street and number)

UNIVERSITY HOSPITAL S.T.U-O.R.

4b. City, Town, or Location of Deeth BALTIMORE

1999 0345 AM 4c. County of Deeth

Funeral

7. Age (In yrs. last birthday) 1 XM 2 ☐ F 409-39-6848 23

If Under 1 Year Months Deys Hours Min

 Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Florida

Director

r 28a-f show

"natural", or items 23s or

r than "nature

7 is marked other traumatic event,

Pages 1 and 2 should be file ment of Health and Mentel Hy ant: If Itam 27 is marked oth lury or other traumatic event

Department of Important: If any injury or

Physician

/Medical

Examine

physician end s the burial-trans

80 980 0

signed by the e

certificate has lirector, page 2 s

this funeral

After

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efter 9 To 24 hours off Funeral Di

To the I

2

director.

death certificate be executed

Records, P.O. Box 68760.

Division of Vital Attending Physician: Directo

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Completed

Be

Examine

Physician/Medical

by

Completed

Be

10

Certification:

Medicai

State Registrar

the Marylend

death

72 hours efter

filed within

Hygiene.

Baltimore, Maryland 21215-0020

10a State Maryland Funerai

10b. County 10c. City, Town or Location Baltimore

Cockeysville

1 ☐ Yes 2 ☑ No

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

USA

Usual Residence of Deceden

319-102 Lord Byron Lane 12. Was Decedent Ever in U,S. Armed Forces?

21030 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.)

14. Race - American Indian. Black, White, etc.

1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

1 ☐ Yes 2 🗽 No If Yes, Give Year or Detes: 15. Decedent's Education (Specify only highest grade completed)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 Yes 2 No Specify:

White 16b. Kind of Business/Industry

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

College (1-4or 5+) 01

12

Computer Consulting

Computer

Stephen

Levin

Mary

22. Name end Address of Fecility

Patricia

Davis

19a. Informent's Name/Relationship (Type, Print)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

Mary Lakhdari/Mother 20a. Method of Disposition

20b. Place of Disposition (Neme of cemetery, crematory or other place) Crematory

319-102 Lord Byron Lane, Cockeysville, MD 20c. Location - City or Town, Stete

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specific

Baltimore-Washington

3/8/99

18. Mother's Name (First, Middle, Maiden Surname)

Laurel, Maryland

21 Sgraph of Funeral Service L Bryan W. Clary disease, or complicate ailure. List only one of

Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest,

21093 Approximate Interval Between Onset end Death

Immediate Cense (Final disease or condition resulting in death)

Mounde DMUNOS

Due to (or as a consequence of)

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last

Due to (or as a consequence of):

Due to (or as e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

28. Place of Death (Check only one)

24b. Were autopsy findings aveileble prior to completion of cause of death?

TTYES 2 □ No 1€ Yes 2□ No

25. Was case referred to medical examiner? NOXYes 2□ No

> 5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) -7-99

Hospital: 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA 28b. Time of Injury VIUK A M

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred DRIVER OFGER

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RODDWMy

28f. Location (Street and Number or Rural Route Number, City or Town, State) CASUSTOOK BY BANTHONE CO, MM

29a. Certifier (Check only one)

27. Menner of Death

1 Netural

20 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

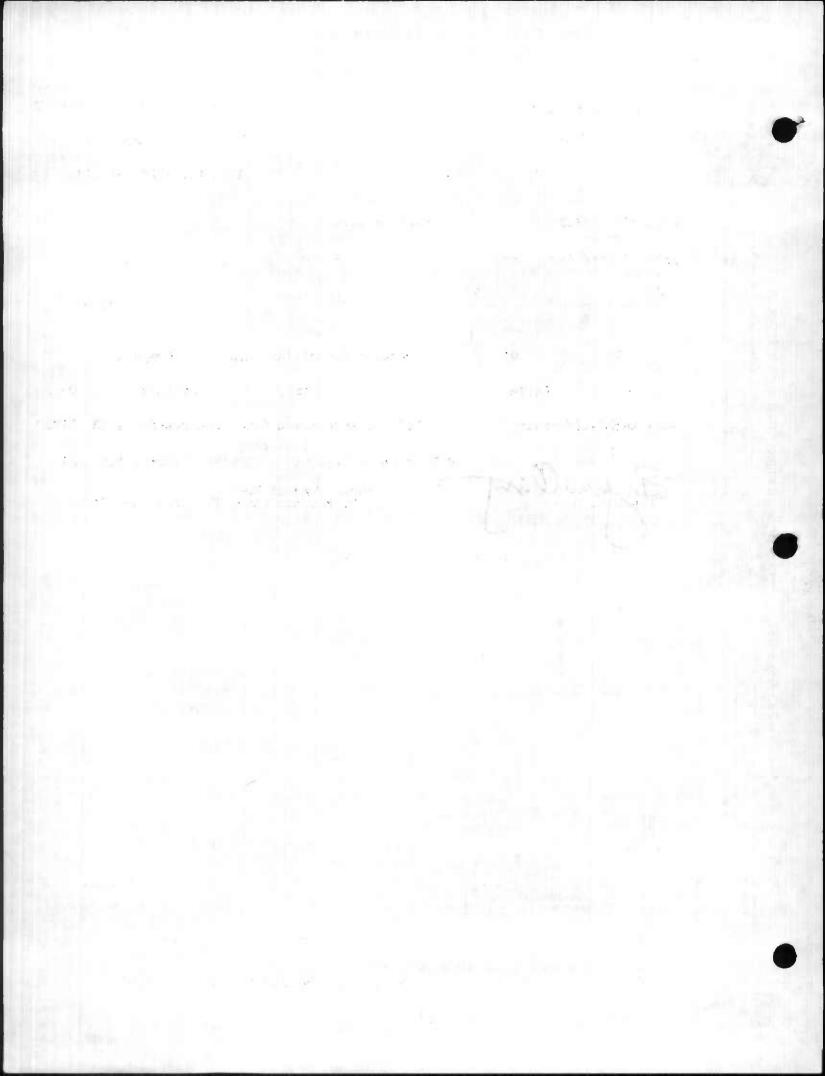
29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) , 1.999 MARCH 8

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

MAMBOURS 31. Date filed (Month, Day, Year) estable. 111 Penn Street, Baltimore, Maryland 21201

MAR 0 9 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month **Physician** Cooper 1999 Long March 6 5:25PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1940 Hillton Road Pasadena Anne Arundel 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1X M 2□ F 213-16-5204 78 Director Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 1940 Hilltop Road "natural", or Items 23s 21122 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ⊠ Yes 2 □ No If Yes, Give Yeer or Detes: WW I 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Meritel Status Bleck, White, etc. 1 □ Never Merried 2K) Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: specify: White þ 3 ☐ Widowed 4 ☐ Divorced WW II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry flied within 7 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) machine shop foreman manufacturing it. Pages 1 and 2 should be tiled virtuent of Health and Mental Hygis rlant: if them 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Elizabeth Edwin Long McDaniel 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. Long 1940 Hilltop Road Pasadena, MD 21122 spouse 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Mt Carmel Cemetery 3/10/99 Pasadena, MD 22. Name and Address of Fecility 21. Signeture of Funeral Service Licenses Stallings Funeral Home P.A. 23a. Pent 1. Enter the disease, or complications met caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last and physician a the buriel Box 68760 Physician/Medical 980 ò Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 XNo 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy parformed? Completed peed 788 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 00 this 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 1 DiNeturel 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deeth. To the Funeral Director: A 2 Accident 3 Sulcide 6 ☐ Could not be 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homlcide the Hospital 29a. Certifier edicai 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature end title ot certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nema and eddress of parson who completed cause of death (Item 23a) (Type, Print) Stead Glenburnie Md. 21061 DR. SHOBHAD. REDDY 7845 OAKWOOD

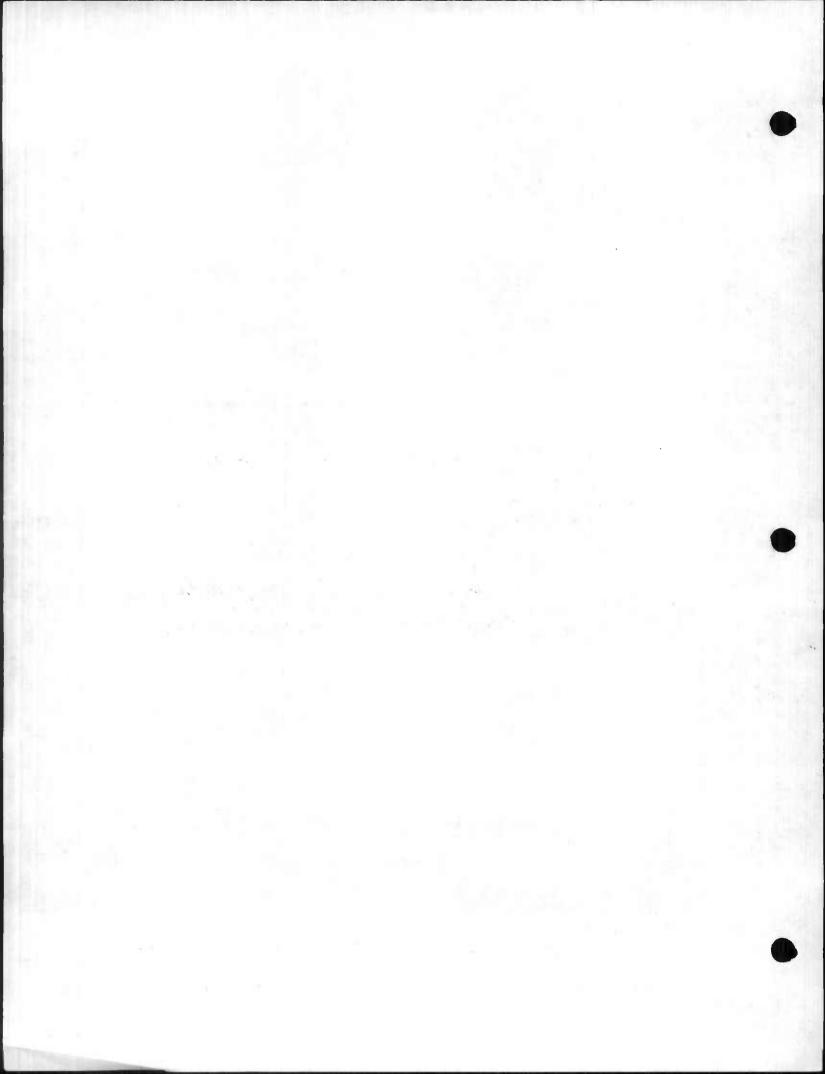
State Registrar

31. Dete tiled (Month, Day, Year)

MAR 9

DHMH 16 Rev 6/95

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 1,1999 JOHN EDWARD LAU March 06,05 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 350 Broad St. PERRYVILLE Cecil Co. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthpiace (Stete or Foreign Country) 1**X** M 2□ F Months Yrs. 220-48-9912 03/22/46 Baltimore, MD 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Cecil Perryville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 350 Broad St. 21903 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 XI Yes 2 □ No if Yes, Give Year or Dates: 166168 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American indien. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced white 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Accounting dept West.MD Railroad 17. Fether's Neme (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surneme) John H. Lau, Jr. Mary E. Reiblich 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Janet M. Symmonds, Sister 7408 Second Ave., Sykesville, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete XBurial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Vet Cem 3/11/99 Garrison, MD 21. Signature of Fyrmai Service Licensee 22. Name end Address of Fecility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the mode of dying, such es cardiac or respiratory arrest, shock, or main failure. List only one ceuse on each line. Intervel Between Onset and Deeth immediate Ceuse (Finel · ASCUD bars disease or condition resulting in deeth) Due to (or as e consequence of): Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieled events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NIDDM, Bigder Disorder 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicei 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2□ No 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred Naturel

Physician /Medical **Examiner**

requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Physician

/Medicai

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

r than "natural", or items 23s or 28s-f show the Maxical Examiner must be notified at

the Marylend

death with

permit. Pages 1 end 2 should be filed within 72 hours efter. Department of Health end Mentel Hygiene. Important: If flem 27 is merked other than "natural", or iter any Injury or other traumatic avant

Baltimore, Maryland 21215-0020

Examiner ettending physician and for use es the bunel-transit Physician/Medicai Completed ial or Attanding Physician: T's effer deeth.

I Director: After this certificat ed in by the funeral director, pi Be To Medicai Certification:

certificate

5 Pending investigation 2 Accident 3 Suicide

6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted.

Madicat Examiner: On the best of exeminerion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier terkos, MD

29c. License number

29d. Date signed (Month, Dey, Year) March 7, 1999

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) It Farkes, MD

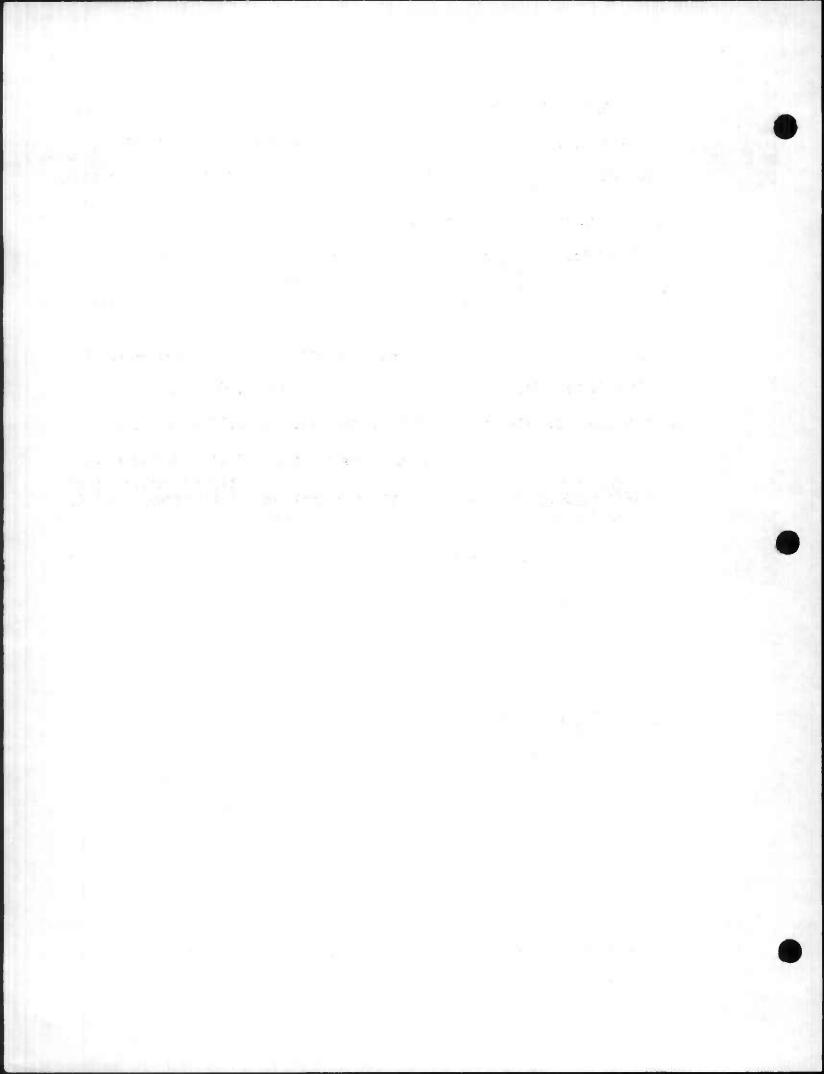
31. Date filed (Month, Dey, Year)

MAR 0 9 1999

planion Hospital, Elkron, Mp 32. Registrar's Signature

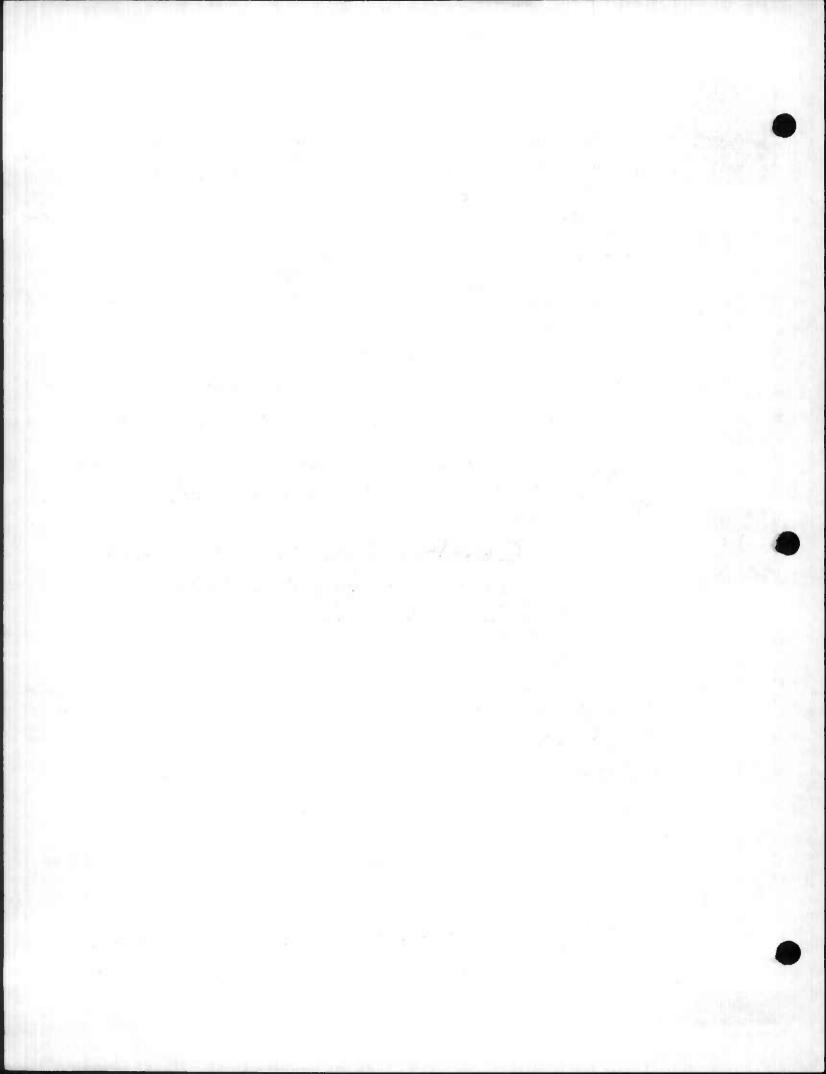
Registrar

To the Hospital within 24 hours e To the Funeral Completely filled Hospital

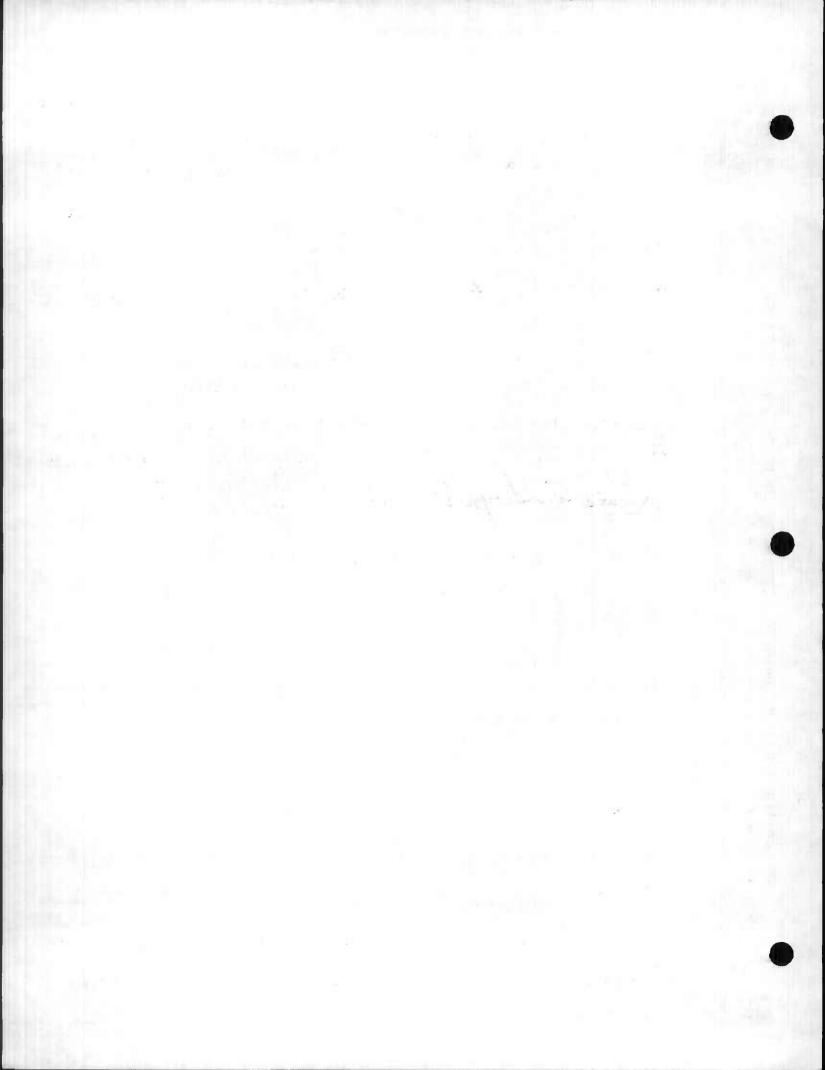


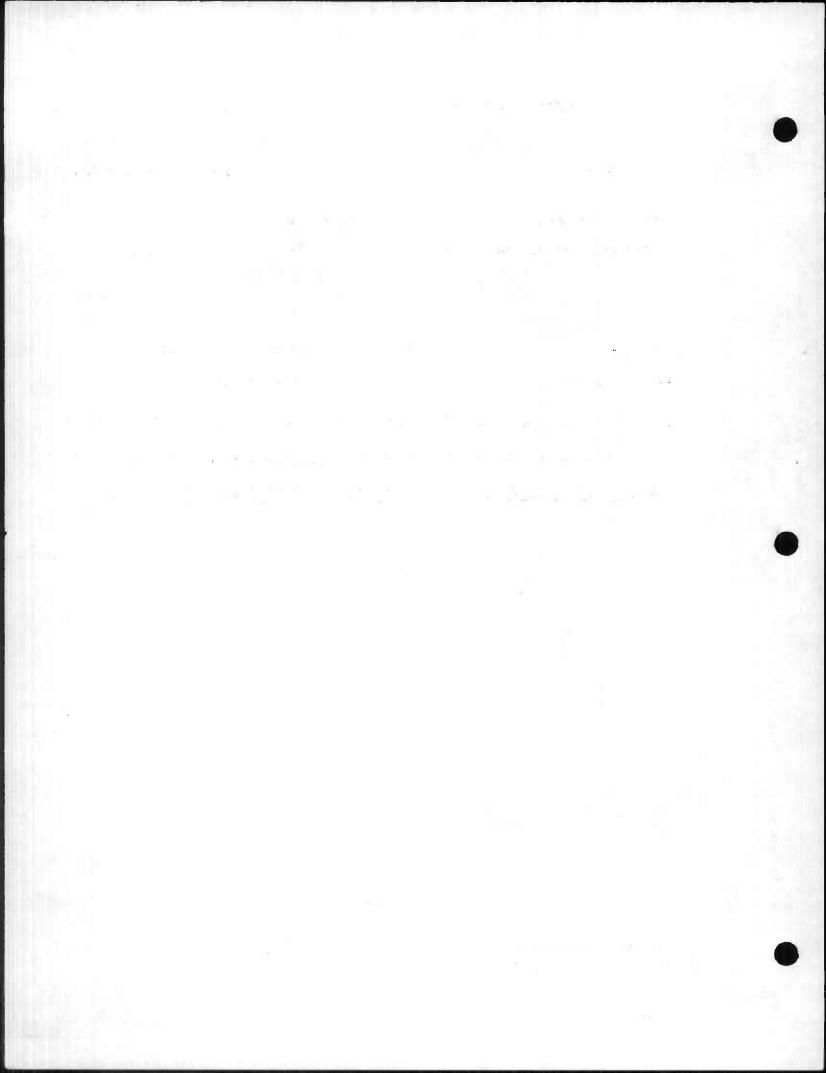
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month HARRY LOWE 1999 3 10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Elder Care Baltimore Baltimore 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stete or Foreign Country) Funeral 8. Data of Birth (Month, Day, Year) 10XM 20 F Days Hours 212-07-3967 Yrs. 84 Director MD Usual Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "naturar," or frems 23a or 28a-f show any injury or other traumatic event, it a Madical Examina man health and injury or other traumatic event, it a Madical Examina 10a. Stata 10h County 10c. City, Town or Location 10d. Insida City Limits MD Baltimore Catonsville Director 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8720 Emge Road 21234 USA Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ONo If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Elamentary/Secondary (0-12) Coilega (1-4or 5+) Brakeman Railroad 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be John Lowe Ada Parker 19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 303 Waveland Road, Catonsville, MD 21228 Jan K. Lowe (Son) 20b. Piaca of Disposition (Name of cametery, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3/8/99 Baltimore, Maryland 21. Signature of Furieral Service Licensee 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onsat and Death **Physician** erebro Varcular Accident /Medical immediete Causa (Final disaasa or condition resulting in daath) **Examiner** Rant directe Examiner ettending physician and for use as the burial-transit be executed Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initieted events rasulting in daath) Last Box 68760. Physician/Medical Dua to (or as a consequenca of) ed by the etter deteched for u Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 111012 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? coma 1 Yas 2 XNo 1 ☐ Yas 2 ☐ No this certificate Division of Vital 25. Was casa rafarrad to medical Be 26. Place of Daeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 Other: 1 Yas Nursing Homa 5 Rasidanca 6 Othar (Specify) funeral 27. Mennar of Daath 28a. Data of injury (Month, Day Year) Hospital or Attending Pl
 24 hours efter death.
 Funeral Director: After th 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 5 Panding Natural invastigation 1 ☐ Yas 2 ☐ No 2 Accidant by the 6 Could not be datarmined 3 Suicida 28a. Place of injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital or within 24 hours eft To the Funeral Di completely filled in 16 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Cartifian Medical 29d. Data signed (Month, Day, Year) 29b. Signatura and little of certific 29c. Licansa number Staf WILtams 1341901 30 Name and address of person who completed cause of death (Item 23a) (Type Print) Parkway, Bulkimure, MD 21214 32. Ragistrar's Signature State Registrar



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10	MD N	/ A		В	ALTIMO	ORE						Yes 2 No
10e.	Street and Number		E V 17			10f. Zip Co	de			10g. Citizen of V	Whet Country?	
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	Method of Disposition 1X Burial 2 ☐ Cremeti	on 3 🗆 Re	emoval from State	0	Place of Dispos cemetery, cremi	atory or other	r place)		Dete	20c. Location -	BA	ALTO.
2	Donation 5 Othe	r (Specify)		KI	NG MEN	MORIAI	L PAR	RK 3/	9/99	BALTIM	ORE, MI). Co.
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:00 PM SARA MORRIS MARCH 4, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3801 CANTERBURY ROAD #801 N/A If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) DEC. 25, 1905 9. Birthplece (State or Foreign 5. Social Security Number **Funeral** 1 M 2 F Days Months LITHUANIA Yrs. 268-24-0801 93 **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yas 2 No N/A MD Director BALTIMORE 10a. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3801 CANTERBURY ROAD #801 21218 U.S.A. death Funeral 12. Was Decedant Evar in U,S.
Armed Forces?

1 ☐ Yas 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black. White, etc. 72 hours after 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE A 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglens important: if item 27 is marked other tha any Injury or other traumatic evant, that page. TEACHER EDUCATION Baitimore, Maryland 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JOSEPH GOLDMAN** CHIA LEPAR 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) ROBERT MORRIS / HUSBAND 3801 CANTERBURY ROAD #801 -BALTIMORE, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 3/8/99 BNAI ISRAEL CEMETERY BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. V 8900 REISTERSTOWN ROAD - PIKESVILLE, MD de 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gerebrovuscular Accident
Amenscleratie Careball After Orseans **Physician** 3weeks Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Examine tha death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events physician and s the burial-trans Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequenca of): 88 980 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 70 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy has page 1□ Yas 2 No 1 Tyas 2 No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 21 No

27. Manner of Death
12 Natural 5
2 Accident Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 Aftar this 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28c. Injury at Work? or Attanding 5 Pending Investigation s after dea... 1 Yes 2 No 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 \ Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date siggled (Monty), Day, Year) 29b. Signature and title of certifier iss of person who completed cause of death (Item 23a) (Type, Print) W. Talenar GITT ND 500 W University Play Baltimore MD 2/2/0 31. Date filed (Month, Day, Year) 32 Registrar's Signature

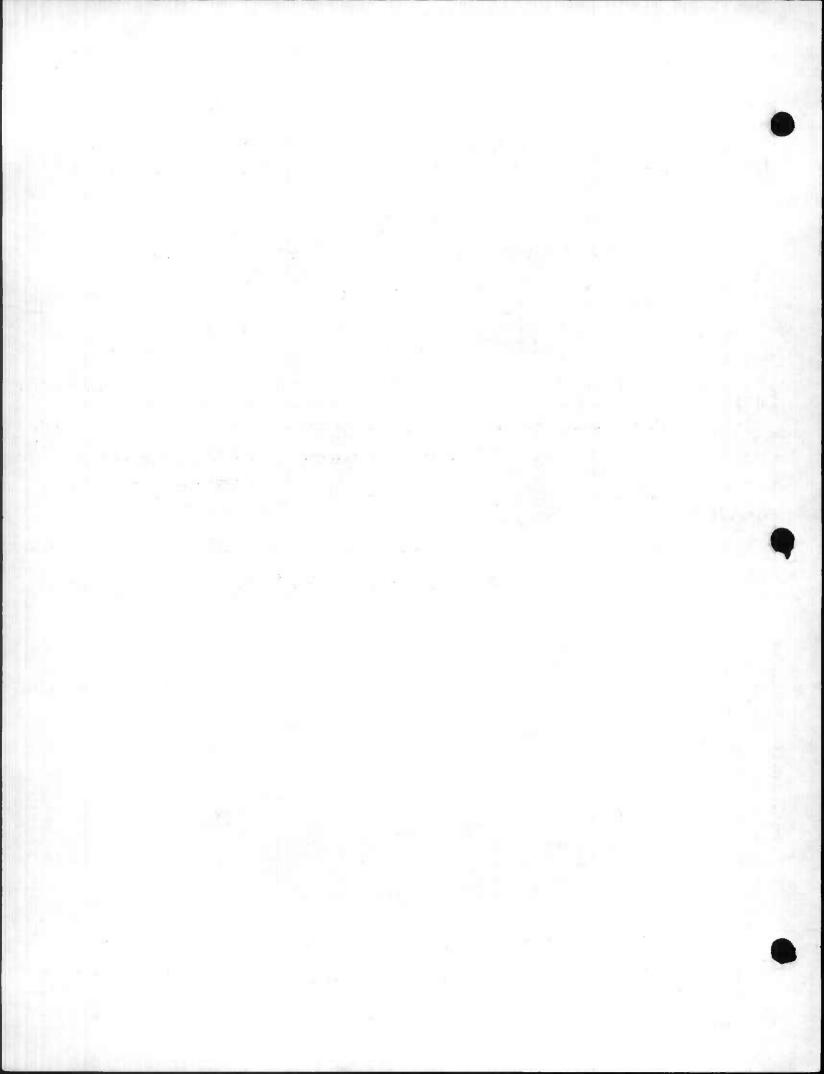
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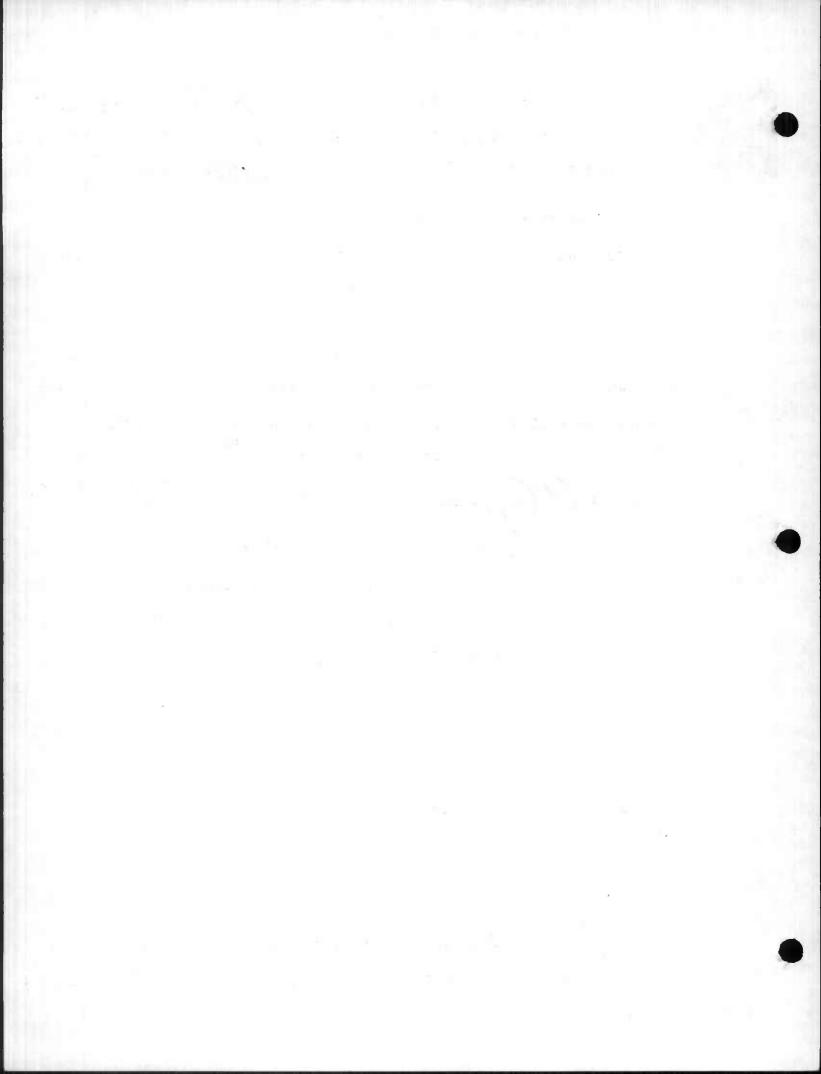
MAR 9



State of Maryland / Department of Health and Mental Hygiene O Item: 9 per F.H G-769 3/10/99 reb Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 0259 MARSHALL GLORIA MARCH /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE CITY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Days 66 Mary land 213-28-7937 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yes 🌪 🗆 No Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1603 Rita Road 21222 U.S. of Completed by Funeral America 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2☐ No If Yas, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White al Hygiene.
d other than "natural event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) i. Pages 1 and 2 should be filed w tmant of Health and Mantal Hygien tant: If Item 27 Is marked other th jury or other traumatic event, the Saleswoman Clothing Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Valentine Holewinski Helena Dombrowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Herbert Marshall (HUSBAND) 1603 Rita road Dundalk, Md. 21222 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, State March 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Sacred Heart of Jesus 12 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224 led the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximete Interval Between Onset and Deeth **Physician** BRAIN STEM HERNIATION /Medical Immediate Ceuse (Final disease or condition resulting In death) minutes Examiner Due to (or as a consequence of): Physician/Medical Examiner HEMORRHAGE INTRACRANIAL hours The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or injury that initiated avents Due to (or es e consequence of): CEREBRAL VASCULAR ACCIDENT Box 68760. the that initiated avents resulting in death) Last Due to (or as a consequence of) HYPERTENSION Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part 1. P.0. 23b. Did tobacco usa contributa to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown DIABETES MELLITUS Records, þ 24b. Were autopsy findings evallable prior to complation of ceuse of death? Completed 24a. Was en autopsy performed? ate has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Division 5 ☐ Pending investigation 1 Matural 1 Yes 2 No 2 Accident 24 hours after deal Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 I Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) To the Vithin 2 29b. Signeture and title of confine 29c. License number 29d. Date signed (Month, Day, Year) RES- POD The RESIDENT PHYSIQAN 8 READ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER 4240 EASTERN AVENUE BALTIMORE, MARYLAND 31. Data filed (Month, Day, Year) 32. Registrar's Signature State MAR 9 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Daath 3. Time of Death 2:40 PM STANLEY WILLIAM MUNE MARCH 4e Fecility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 441 Chalfonte Drive Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 1 M 2 □ F 7. Aga (In yrs. last birthdey) Birthplece (State or Foraign Country) Yrs. 91 Oct. 6, 213-03-2286 Maryland Usual Rasidance of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 441 Chalfonte Drive 21228 USA 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 📉 No If Yas, Giva Year or Datas: 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 No Spacify: White 3 ₩ Widowed 4 Divorcad 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada complated) 16b Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 10 Printer Printer Company O 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Louisa Mae Albrecht Charles Henry Mund 19b. Maiting Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Raletionship (Type, Print) 441 Chalfonte Drive, Catonsville, Maryland 21228 William S. Mund, Jr. / Son 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3/8/99 Baltimore, Maryland 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Dicensas Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or compilications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Approximeta Interval Between Onset and Deeth Immediate Ceuse (Finel STROKE disaasa or condition resulting in deeth) Dua to (or as a consequence ot) Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated avants resulting in daath) Lest Dua to (or es a consequenca of): Due to (or as e consaquanca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown preumonia 24b. Wara autopsy findings available prior to 24a. Was en autopsy performed? Myocardial infarction completion of causa of death? Parkinson's disease. 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa refarred to medicat axaminar? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Yas 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No Investigation 2 Accidant 6 Could not be datermined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Phyalcian: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and mennar as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, data and place, and due to the causa(s) and menner stated. 29a. Certifier

Records, P.O. Division of Vital t or Attending efter death. Director: Aft 24 hours e Funerel D To the Hosp within 24 ho To the Fune completely fi

Physician

/Medical

Examiner

Director

Funeral

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Completed

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permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manylen Depertment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any inlury or other than the word, The Modelle Eschington matter profited as

Physician /Medical

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altimore, Maryland 21215-0020

State Registrar

31. Deta filed (Month, Day, Year) MAR 0 9 1999

KOMAL K. DANG

29b. Signatura end titla of certifier

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(Check only one)

3455, M.D. 32. Registrar's Signature

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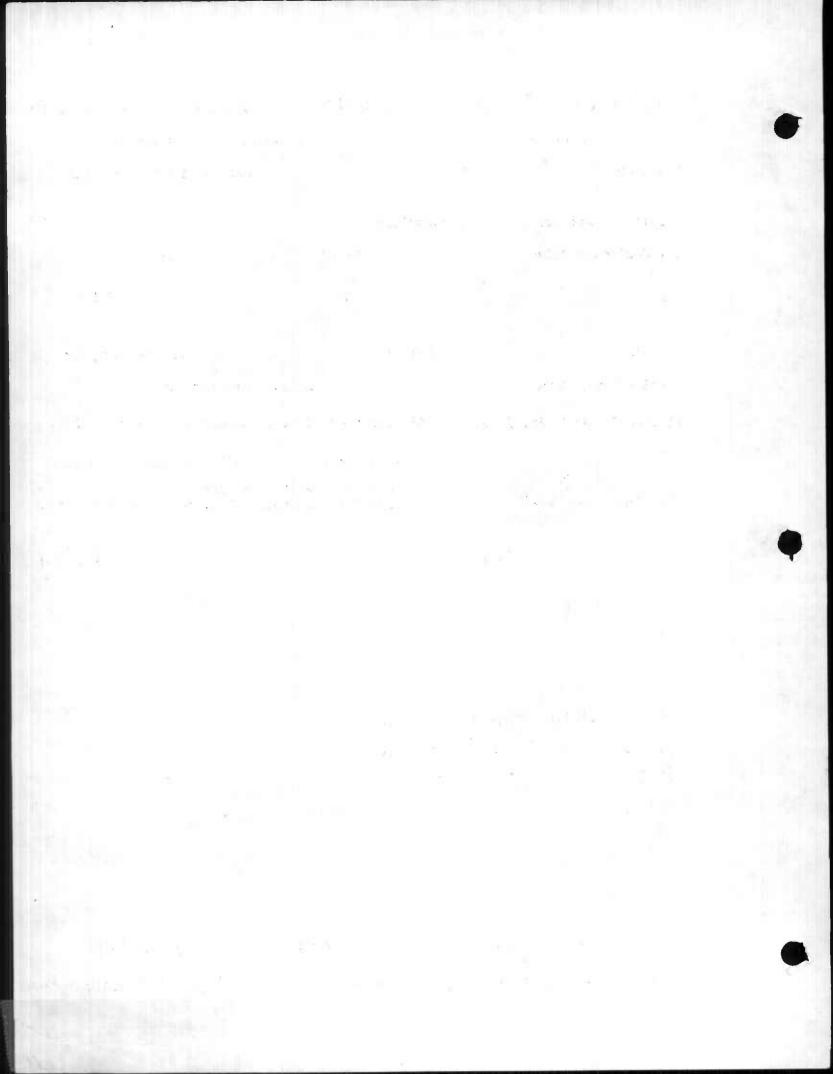
30. Nama and addrass of person who completed causa of deeth (Item 23e) (Type, Print)

Wilkens Are Suite 308 Balto. Md21229

29d. Date signed (Month, Day, Year)

29c. License number

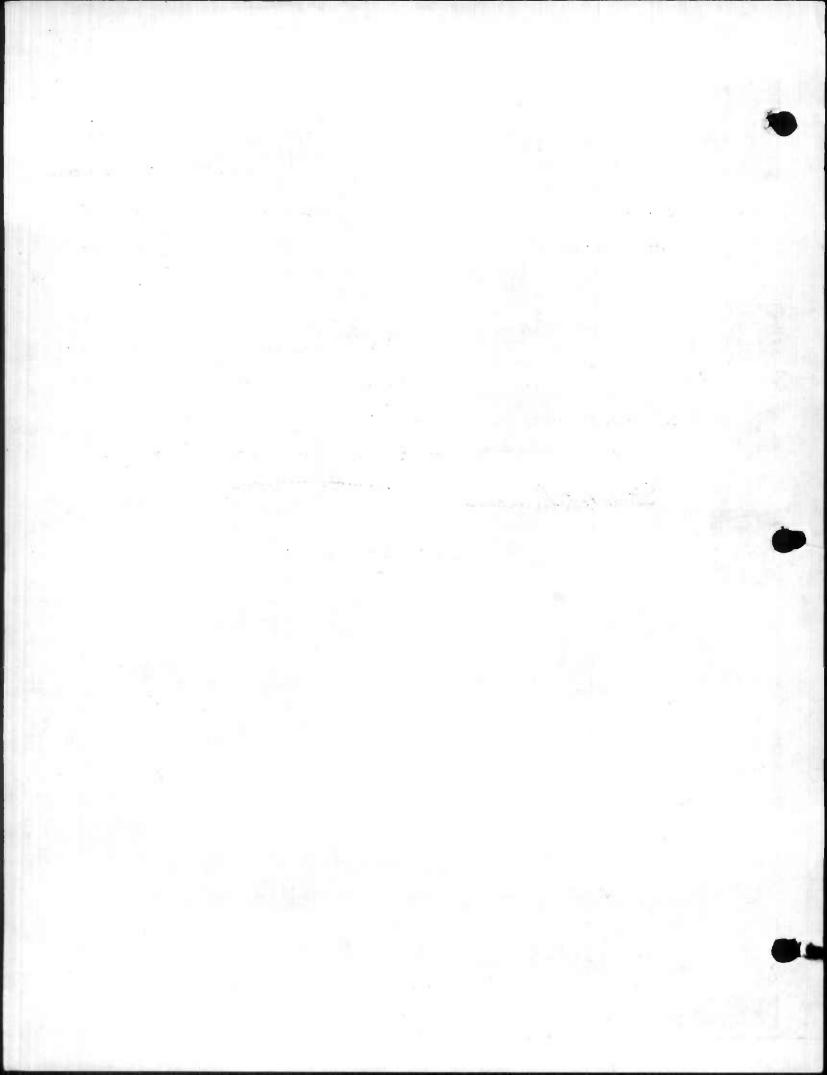
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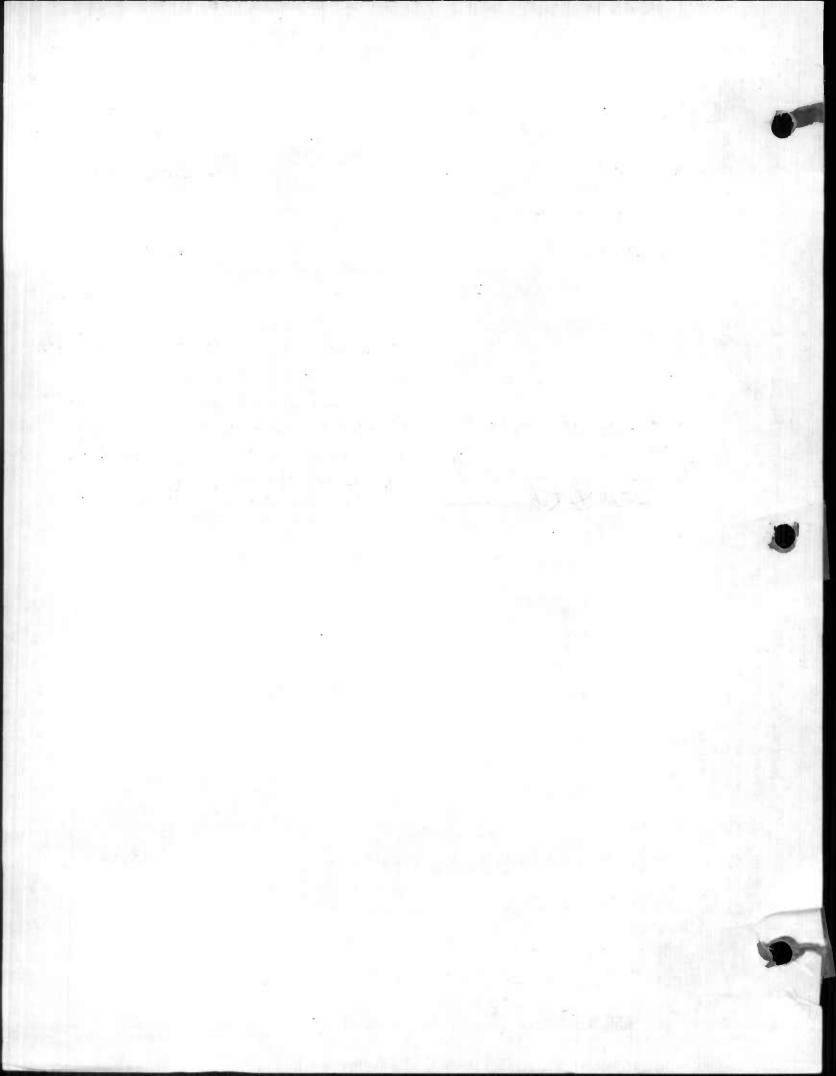
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Physicia	_	Decedent's Name (First, Middle, Last)						2. Date of Dea Month		Year	3. Time of Death	
/Medic		Enoch	G.			Mason		March		999	8:30 AM	
Examin	er	4a Facility Neme (If not institution, give					4b. City, Town, or I		4c. County		1-	
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Funeral Director		5. Social Security Number 212 18 0621 Usual Residence of Decedent	7. Ag	79	ast birthday Yrs.	Months Day		8. Dete of Birth (Month, Day NOV • 27	, Year) 919	9. Birthp Cour Ma:	elace (State or Foreign stry) ryland	
15-0020 72 hours after death with the Maryland netural; or terms 23s or 28s-f show oftest Examiner must be notified at	tor	10a. State 10b. County Maryland n/a		10c. City	, Town or L	ocation	Baltimore			1	0d. Inside City Limits Yes 2□ No	
	al Director	10e. Street and Number 3710 Gwynn Oak Av	re.			10f. Zip Code	21207	1	10g. Citizen of What Country? United States			
020 ours after deal all, or floring	by Fur	11. Meritel Status 1 [X] Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 Xi If Yes, Give Year or Detes:		S. 13.	Wes Decedent of If Yes, specify Co	f Hispanic Origin? (S uban, Mexican, Puert o <i>Specify</i> :	pecify Yes or No- o Rican, etc.)		k, White,	an Indian, etc. Black	
15-002 72 hours	Pted	15. Decedent's Edu (Specify only highest grade			16a. Deci	edent's Usuel Occ	upation ne during most of wor	kina	16b. Kind of B	usiness/Ind	dustry	
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laryland 2 2 should be filed and Mentel Hygi a marked other surratic evant, I	၉				Mason							
CINL		19a. Informant's Name/Reletionship (Ty Deborah W. Harriso					et and Number or Ru ood Rd., A			State, Zip 2230		
Pages nent of int: If its		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emovet from State	CE	emetery, cre	osition (Name of ematory or other p unt Crem		Dete 9/99	20c. Location - Baltin			
Baltimo pemit. Page Department of Important: If any Injury or		21. Signature of Funeral Service License	7		C		dress of Fecility then D. Lo en Pasture			e, M	D 21286	
Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart feilure. List only or Immediate Ceuse (Finel disease or condition resulting in death)	- 1	osta	1	Cosci	,			1	Interval Between Onset and Death	
760 te be ysicia	Physician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest			as a conse	quence of):						
Death death difor (clai	Pert II. Other significant conditions cor	tributing to death h	ut not resu	ilting in the	underlying cause	niven in Pert I	23h Did to	obacco usa do	ntribute to	the cause of death?	
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of Vital Records, P. Physician: The law requires that this certificate hes been signed b rail director, page 2 should be deta	Completed							24a. Wes e perfor		av co	ere autopsy findings eilable prior to impletion of cause death?	
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Attending In death.	atlon	1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	V	vork? □ Yes 2 □ No		,,			
Division at or Attending a star death. Follector: After din by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, etc.	ury - At ho c. (Specify	me, ferm, s	treet, fectory, offic	X8	28f. Location (S City or Tow	itreet and Numi n, State)	oer or Run	al Route Number,	
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within 2		29b. Signeture end title of certifier	0	0	0	29c. Lice	nse number		29d. Date signe	d (Month,	Day, Year)	
		10, 8, Wal	ten 41	KI /	11.	01	7154		3/8	199		
		30. Name and address of person who co	mpleted cause of d		1				-		76. 6	

State Registrar



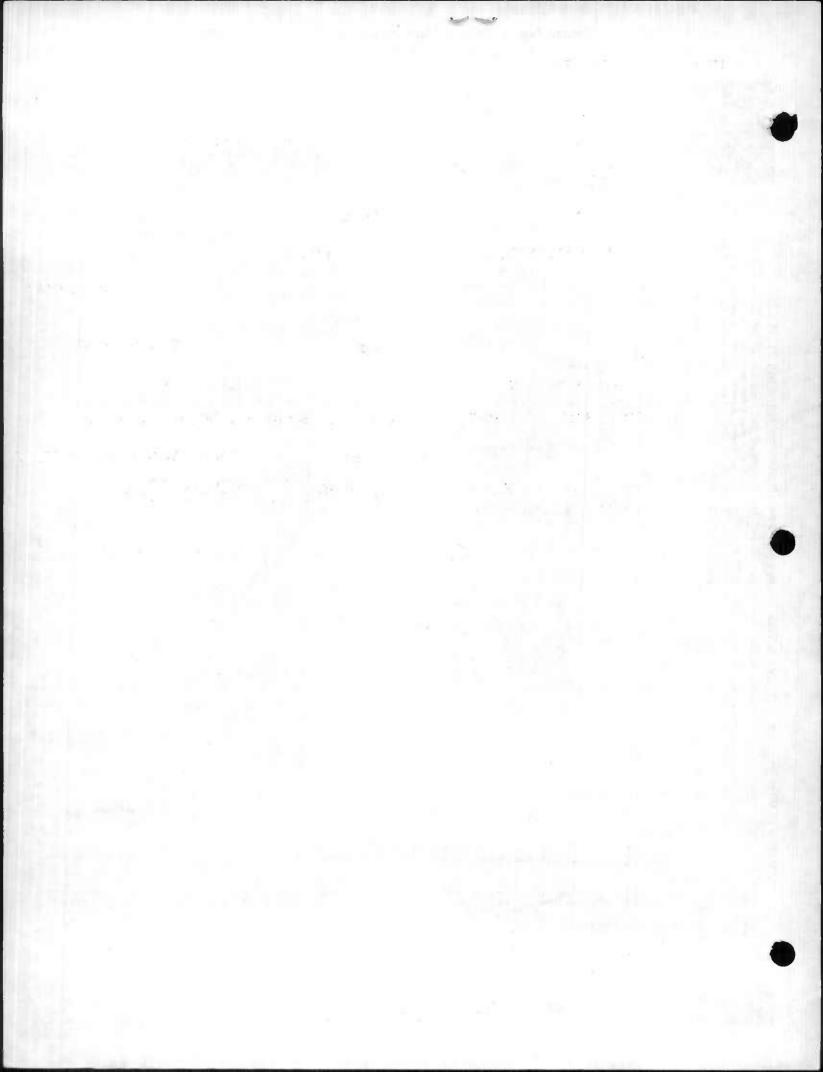
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** ALIGMILLER 1999 March 4:00 AM /Medical 4b. City. Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) 252 Oak Ave. Baltimore Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Deys Hours 1□M 20 F 88 Yrs. 213 18 7985 Sept. 15,1910 Virginia **Director** Usuet Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23s or 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Baltimore Baltimore Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 252 Oak Ave. 21219 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Yes ZONO 1 Never Merried 2 Married 1 Yes 2 No Specify. White Maryland 21215-0020 Specify: þ 3 XWidowed 4 ☐ Divorced Year or Detes: d Hygiens. other than "natural", Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Beauty Salon / Shop Beautician 8 17 Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of Pearl Jackson McMahon Eugenia James Frank 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Betty Lou Weber / Daughter 252 Oak Ave., Baltimore, MD Baltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 3/8/99 Green Mount Crematory Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture a Funerel Service License 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 Johnson 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel Medastaku Lung Concer disease or condition resulting in deeth) Examiner Examiner death certificate be exacuted signed by the attending physician and d be detached for use as the bunal-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as e consequenca of): Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contributs to the cause of death? P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 3 Unknown 1 Yea 2 No Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy should peed has page 2 1 Yes 2 Tho 1 ☐ Yes 2 ☐ No certificate Division of Vital director. Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Passidence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28e. Dete of Injury (Month, Dey Year) funeral 28c. Injury at Work? 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Attending 1 Netural 1 Yes 2 No Within 24 hours after death. To the Funeral Director: Af 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At Inome, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. Medical 29e. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date aigned (Month, Day, Year) 29b. Signature end title of certifier Waterburg, G.D. 30. Name and address of person who completed cause of death (trem 23a) (Type, Print) 4940 EASTERN AUE. BALT. MA 21224 JH84C WATELBURY MD 32. Registrer's Signature State MAR 0 9 1999 Registrar

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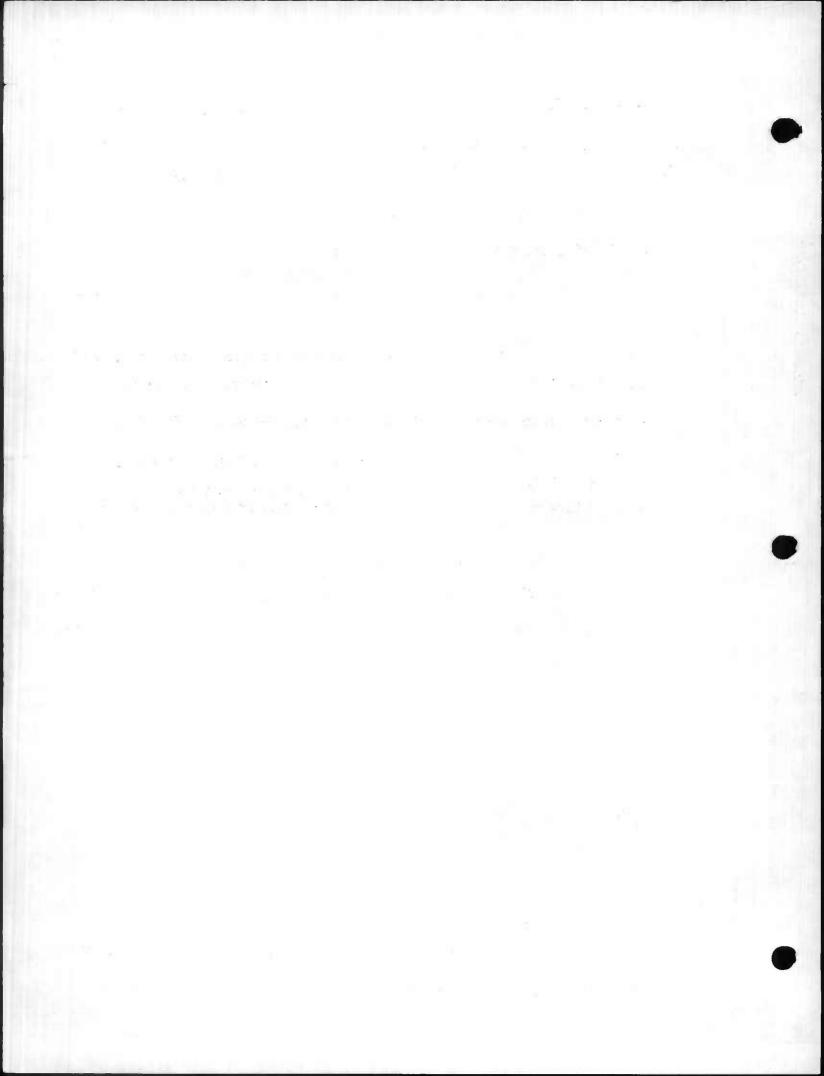
State of Maryland / Department of Health and Mental Hygiene Q AMEND ITEM: #25 PER MD G781 3-7-2000 WR. Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth. Month 5 **Physician** 4e Fecility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALT If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 6/5/36 USDITAL N/A SECUUDS 7. Aga (In yrs. last birthday) If Under 1 Year 9. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1□ M 2# F Hours 62 Director VIRGINIA 231 38 3094 Usuel Residence of Decedent the Maryland 10a, Stata 10c. City. Town or Location 10b. County 10d. Inside City Limits ahow 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1∰ Yes 2 No MD. N/A Director BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1119 ASHBURTON ST. 21216 USA Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus filed within 72 hours aftar 1 ☐ Yas 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Merried Specify: AFRO AMERICAN 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiana. WESTVIEW LOUNGE CHEF 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Pagas 1 and 2 should be f nent of Haalth and Mantal I int: If Item 27 ta marked of LAW EARLY ANDERSON LAW 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) HUBERT W. MILLER HUSBAND 1119 N. ASHBURTON ST. BALTO. MD. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from Stata permit. Paga Department of Important: If any Injury or once. ARBUTUS PARK 4 ☐ Donetion 5 ☐ Other (Specify) 3/10/99 ARBUTUS, MD. BALTO. CO 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility ESTEP BROTHERS 1300 EUTAW PL. FUNERAL HOME P.A. BALTO. MD. 21217 23a. Pert1. Enter the disease, or complications that counsel the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one couse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Examiner PChGOSBONC physician and s the burial-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Lest A76ERUSCL SEVENE Physician/Medical attanding pl SCENdING signed by the a d be datached f Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings eveilable prior to completion of causa of deeth? 24e. Wes en eutopsy performed? Completed cartificate has b 1 Yes 2 No 1 Yes 2 No Be 25. Wes case referred to medicel examiner?
1 ☑ Yes 2 ☐ No diractor 26. Piece of Death (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) funaral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? i or Attending P after death. Director: After I Certification: Aftar 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 24 hours after Funeral Dire lataly filled in b 15 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and menner stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune complately f (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifia 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Mile LANE 3502 mitH 21208 HENRY 31. Data filed (Month, Dey, Year) MAR 0 9 1999 32. Begistrer's Signeture State

Registrar



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4	State of Maryland / Department of Health and M Certificate of Death	lental Hygiene 9 Reg. No.	0/44/
Physician	1. Decedent's Neme (First, Middle, Last) Katherine T. Morris	2. Dete of Deeth Month Dey March 7	Year 999 Scan
/Medical Examiner Funeral Director	4b. City, Town, or Lot Frank I'm Square Hospital Center Rose of Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min.		
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ING 21215-0020 be filed within 72 hours efter death with the Manylend tal Hyglene. d other than "naturel", or items 23s or 28s-f show event, the Medical Evaniner must be nothing at Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 3 O Sewing Machine Opera	ing	usiness/Industry
Maryland 212 2 should be filed with h and Mental Hygiene. 7 is marked other than treatments event, the M		rine Irene Hur	,
Mar nd 2 sho lith and 27 is my	19a. Informant's Neme/Relationship (Type, Print) Susan Setzer / granddaughter 19b. Meiling Address (Street end Number or Rural 18 Brigantin Ct., Balt		
altimore, mit. Peges 1 er pertment of Nee portant: If Itam: y Injury or othe	20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Metro Crematory 3		City or Town, State
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DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (27. Manner of Deeth 1 Natural 5 Pending (Month, Dey Year) 2 Accident Investigation Control Power of Development (Month, Dey Year) 28b. Dete of Injury (28b. Time of thijury Work? 1 Yes 2 No	me 5 ☐ Residence 6 ☐ Oth 28d. Describe how injury occur	rred
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he Hospi in 24 hou he Funer pletely fil	29a. Certifier (Check only one) 1 Certifying Physician To the best of myknowledge, deeth occurred et the time, dete end plece, the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, determine the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, determine the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, determine the basis of examinetion end/or investigation.		
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4		nore MD	21237
State Registrar	31. Dete filed (Month, Dey, Year) MAR 0 9 1999 Serves G		
DHMH 16 Rev 6/95			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Year **Physician** Lettie Noble Mallard February 25, 1999 4:48 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 102 Challedon Drive Walkersville Frederick 7. Age (In yrs. last birthday) if Under 1 Year if Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) Birthpiace (State or Foreign Country) **Funeral** Days 1□M 20 F Yrs. **Director** 240-70-9051 100 August 15, 1898 North Carolina Usual Residence of Decedent r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. insida City Limits 1 ☐ Yes 2√ No Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 102 Challedon Drive 21793 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Dacadent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 27 No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: by Specify: White 3 ₩ Widowad 4 Divorcad Year or Datas: Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 11 housewife home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi end Mental F marked P Ivey Gaston Noble Sarah Ivey Whaley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 69 permit. Pages 1 and 2.
Department of Heelth el
Important: if Item 27 Is
any Injury or other trau Roger Mallard -5100 Springwood Drive, New Bern, North Carolina 28562 son 20b. Placa of Disposition (Neme of cemetery, crematory or other place)
Pleasant Hill Christian Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3-1-99 5 Other (Specify) North Carolina 21. Signature of Funeral Service Lic 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, MD Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical Chronic Obstraku Palmonary Disease 30 years Examiner Due to (or as e consequence of): Examiner -tran Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury pue Due to (or as a consequenca of): bunial-1 physician s the bunal Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ≥ Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy Completed page 2 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 P.O. Division of Vital Records,

or Attanding Physician: after death. Director: After this carific P C 24 hours a Hospital pletaly within 2 To the

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Baltimore, Maryland 21215-0020

State Registrar

Medical

Micheal Lerner MD

4 - Homicide

(Check only one)

29b. Signature and title of cartifiar

29a. Certifier

29c. Licensa number D41619

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

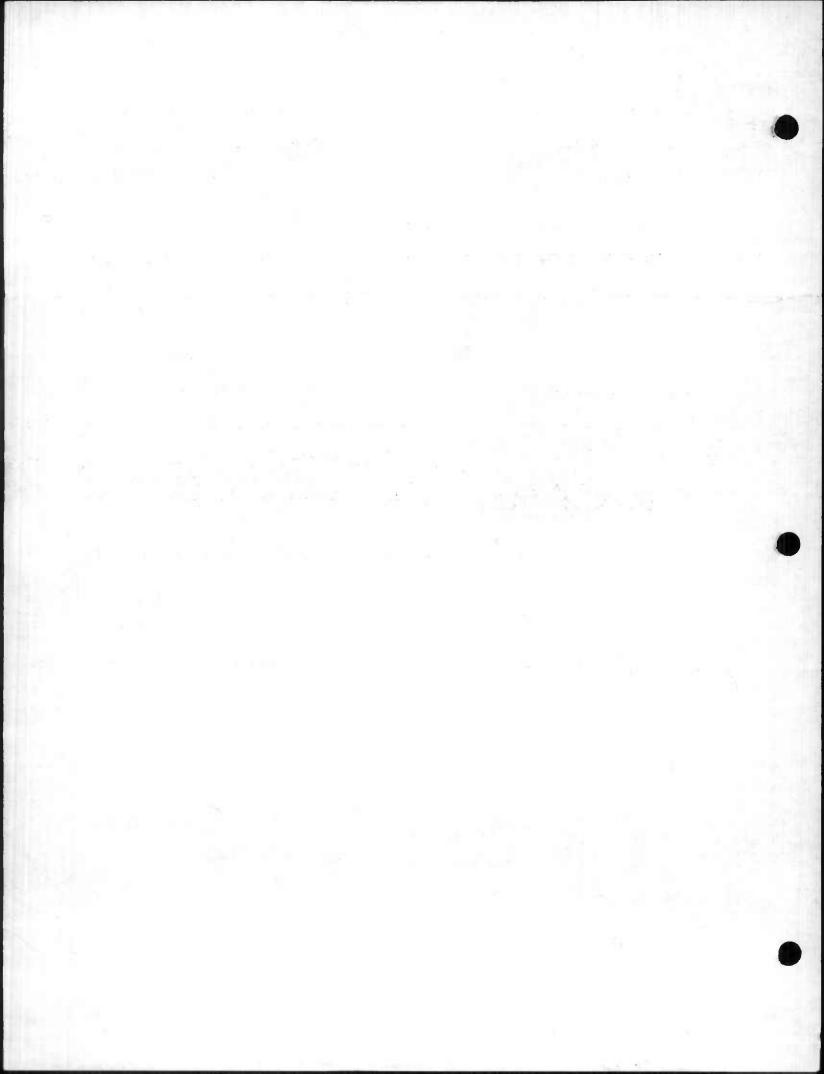
29d. Date signed (Month, Day, Year) March 1, 1959

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. Box 310 Walkersville, MD 21793

32. Registrar's Signature 1999

12 certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and menner as steted.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Vee PHYLLIS K. MURRAY MARCH 1999 2:10AM 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth 7707 Windy Ridge Baltimore County Baltimore 5. Sociei Security Number If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) 1 □ M 2 X F Deys Hours Yrs. 74 Oct. 4,1924 Maryland 218-18-2511 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Maryland Baltimore Baltimore County 1 ☐ Yes XX No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7707 Windy Ridge 21236 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American indien, 11. Maritei Stetus Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes XNo Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) Coilege (1-4or 5+) Homemaker Homemaking-Own Home 12 yrs. N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Joseph Hugo Michel Kathryn Barbara Weilert 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 3710 Evergreen Avenue Baltimore, Md. 21206 Mrs. Patricia A. James (Daughter) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from Stete Moreland Mem. Pk. Cem. 3-8-99 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervei Between Onset end Deeth Immediate Cause (Finei Cardiamyopeth diseese or condition resulting in deeth) Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 3 robably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings eveilable prior to completion of ceuse 24a. Wes en eutopsy performed? of deeth? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

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filed within 72 hours efter

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical

21215-0020

Baltimore, Maryland

Funeral Director

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Completed

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physician and s the burial-transit NS9

Physician/Medical þ Completed Be

Box 68760 signed by s certificate has been si director, page 2 should

P.O. Records, Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p Division of To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

MURRAY

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State Registrar

Examiner Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in death) Lest Pert ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. Chronic obstructive pulmonary discon 25. Wes cese referred to medical exeminer? 1 | Yes 2 | 10 Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 28c. injury et Work? 28d. Describe how injury occurred 27. Menner of Death 28e. Dete of injury (Month, Dey Year) 28b. Time of 1 Da Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signeture end tille of c 29c. License number 29d. Dete signed (Month, Dey, Year)

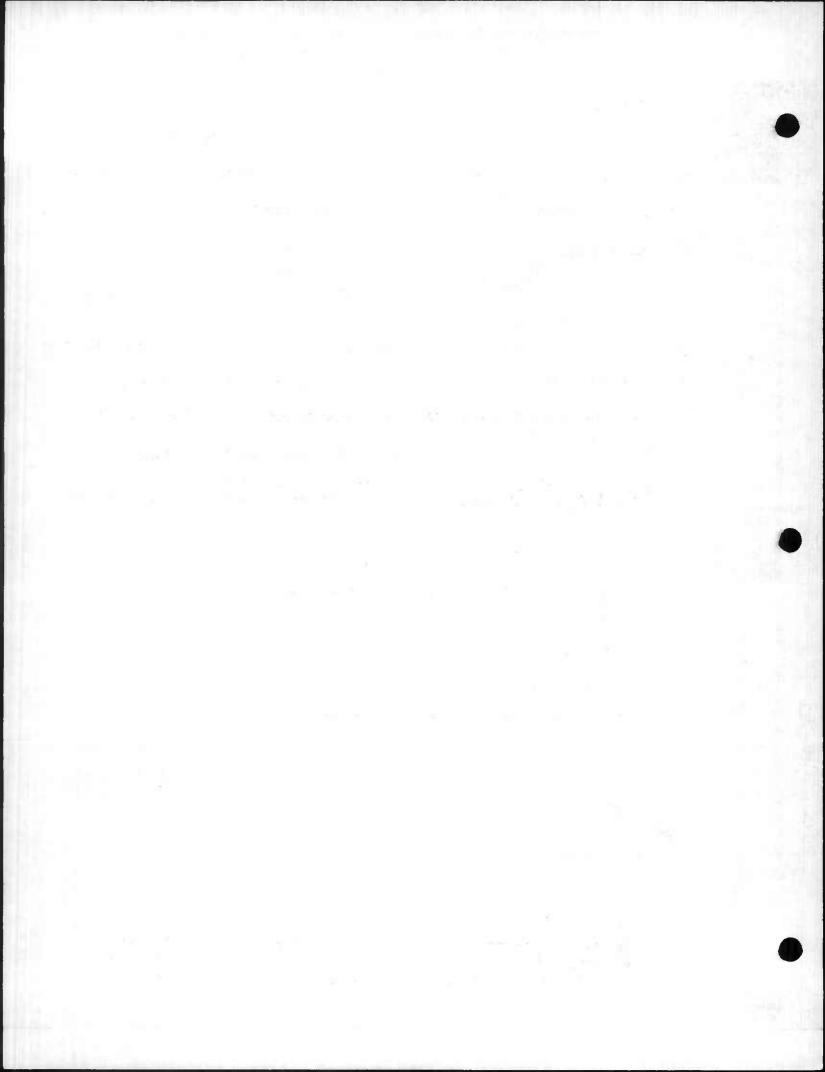
30. Name end ed who completed ceuse of deeth (Item 23e) (Type, Print) IraT. Fine Mis Fills Rol 10753

Lutterville Md 21093

31. Dete filed (Month, Dey, Year)

MAR 9

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month 5, Day 1999 Louis E. Maas, Jr. 3:03PM 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death 1407 Glenwilde Road Catonsville Baltimore If Undar 24 Hrs. 5 Social Security Number ff Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpleca (Stata or Foraign Country) 1 ☑ M 2 ☐ F Months Days Hours Yrs. 79 215-16-2048 March 16, 1919 Maryland Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Baltimore Catonsville 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 1407 Glenwilde Road 21228 USA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian Bleck, Whita, atc. 1 Navar Marriad 2 Married 1 √Yas 2 No If Yes, Giva Yaar or Datas: 1 Yas 2 No Spacify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Businass/Industry 16a. Decedant's Usual Occupation 15. Decedant's Education (Give kind of work dona during most of working life. DO NOT usa retired) (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) Letter Carrier U.S. Postal Dept. 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nema (First, Middla, Last) Louis E. Maas, Sr. Bessie (B.) 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Linda F. Maas, Wife 1407 Glenwilde Road, Catonsville, MD 21228 20b. Placa of Disposition (Nama of camatary, cramatory or othar placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State 3/9/99 Sykesville, MD Lake View Cemetery 4 Donation 5 Othar (Spacify) 22. Nama and Addrass of Facility 21. Signature of Juneral Service Doensee Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the diseesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) ARTERY DISEASE Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Diseasa or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequance of): Part II. Other, algriftcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? TENS/ON 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performad? KOKE 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical 26. Place of Daath (Check only one) 2000 Othar: 4 Nursing Homa 5 Assidance 8 Othar (Specify) 1 Yes 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3□ DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 28d. Dascribe how injury occurred 28b. Tima of 1 (Matural 2 No 1 Yas invastigation 2 Accidant 6 Could not be datamened 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, tarm, straat, tactory, office building, atc. (Spacify) 4 ☐ Homicide

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Baltimore, Maryland 21215-0020

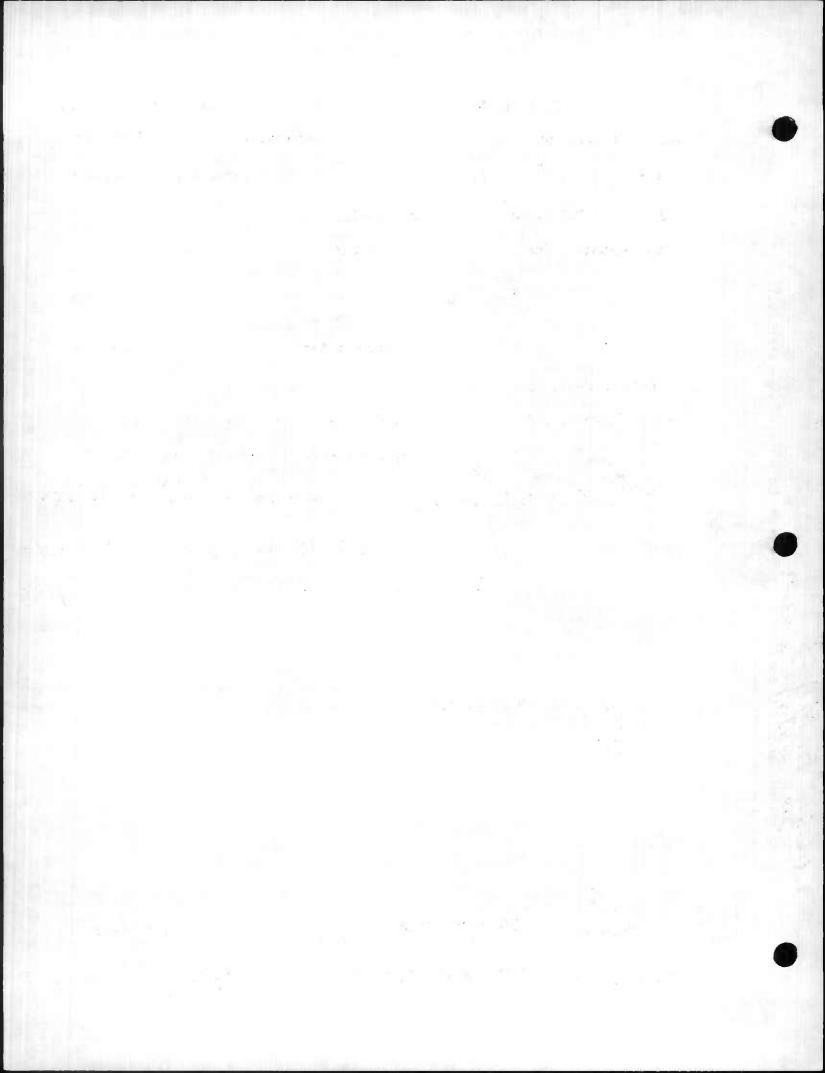
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Registrar

1 Cartifying Phyalcian: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Madicat Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s)

egith (Item 23a) (Dugo, Point) MAIDEN CHOICE LANE 10. BALTIMORE, MD 2/228 Ir's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Me CAIN ROBERT m. 99 Ton /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth **Examiner** Baltimore Denninghaus 106 If Under 24 Hrs. 7. Age (fn yrs. lesf birthday) 8. Dete of Birth (Month, Dey, If Under 1 Yeer 5. Sociei Security Number 6. Sex 1 M 2 ☐ F Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 217-38-1268 55 Yrs Md Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 7 is marked other than "natural", or itema 23a or 28a-f shor traumatic event, "ne Madical Expresser must be notified at 1 Ves 2 No MD Director Daltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Rd. U.S. A Denninghaus 21212 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Meritei Stetus Black, White, etc. Peges 1 and 2 should be filed within 72 hours effer in an of Haalth and Mental Hygiana. Int: If Itam 27 Is marked other than "natural", or ite 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify þ Black 3 Widowed 4 Divorcad Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondery (0-12) Balto. C.ty Janitation Engineer 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Ma Burnell Hopkins lice 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Depertment of Health ar Important: If itsm 27 is any injury or other trau once. Balto, McLain 706 Benning haus . 21212 assandra 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete ₩ Buriel 2 Cremetion 3 Removel from Stete Ridge Cem. 3 11 Balto. 4 ☐ Donetion 5 ☐ Other (Specify) Druid 99 22 Name end Address of Fecility 21. Signature of Funeral Service Licensee Sons orton orton SI 21211 appros 1701 Laurens 23a. Part I Enter the disease, or complication that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, should be heart feiture. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediete Cause (Final disease or condition resulting In death) /Medical **Examiner** Examiner oca physician end s the buriel-trensit law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that Initialed events resulting in deeth) Lest Due to (of es e consequença of Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): attending a ed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by d 25 No 3 Probably 4 Unknown 1 Yes p 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was an eutopsy Completed peeu page 2 254 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes cartificata Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this cartifica director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Dete of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending 1 Tes 2 No Investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or Investigetion, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) and menner steted. edical 29e. Certifier complataly To the To the To the I 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -12990 30. Name end/address of person who completed cause of deeth (item 23e) (Type, Print) MD 21284 1086 YUKIL RD TOWSON (Low MD 32. Registrar's Signeture 31. Dete filed /Month. State Registrar

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32. Registrer's Signature

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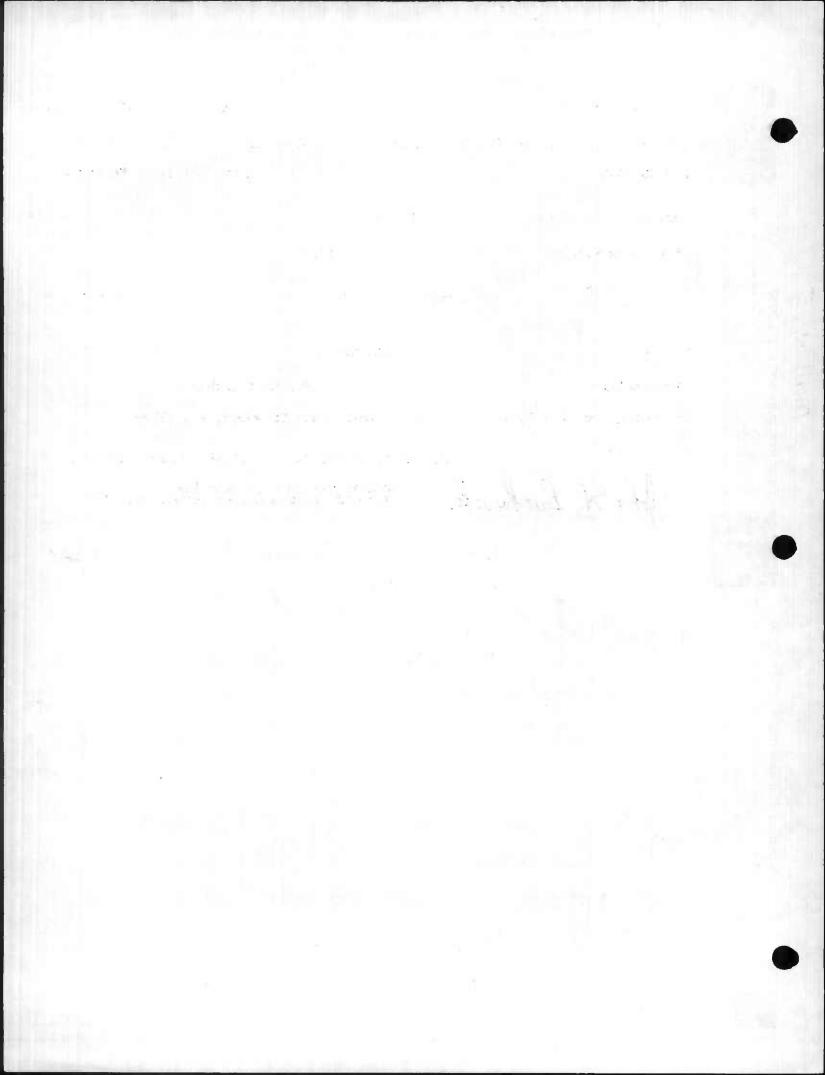
DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Yeer)

MAR 0 9 1999



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 8:38 Pm James J. Murtha March 999 /Medical 4c. County of Death 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner KOS If Under 24 Hrs. Frank Hosbita enter seda e TIMORE 2g, uare 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 09/03/1916 Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min. 1 → M 2 □ F 201-10-5507 82 Yrs. Pennsylvania Director Usuel Residence of Decedent 10e Stete 10c. City, Town or Location 10b County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified at the Meryle MD N/A Baltimore MYes 2 No Director 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 21 Belinda Avenue 21206 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus Bleck, White, etc. 1 Never Married 2 ☑ Married 1 Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced Department of Heelth and Mental Hyglene. mportant: if hem 27 is marked other than "natural", 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Train Operations Assistant Con-Rail 12 18. Mother's Name (First, Middle, Meiden Surneme) 17 Fether's Neme (First Middle Last) Be Peges 1 and 2 should be nent of Heelth and Mental Bartholomew Rose Gibson Murtha 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 21 Belinda Avenue Baltimore, Maryland 21206 Margaret C. Murtha/Wife 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Parkwood Cemetery 3/9/99 Baltimore, Maryland 4 Donetion 5 Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility john C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 ations thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, to ceuse on each line. 23a. Part1. Enter the diseese, or corporations, or heart feilure. List only of Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel ardiolascular I diseese or condition resulting in death) Examiner Examiner ardiac Vascula buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest and Due to (or es e consequenca of): attending physician for use as the burle Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): signed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy peeu 1 ☐ Yes 2 RNo 1 □ Yes 2 □ No Division of Vital f or Attending Physician: efter deeth. Director: After this certifica funeral director, 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending Investigation 1 Naturel 1 Tyes 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner es steted.

2 Medicat Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) and menner steted. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier Casami Aus 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore Maryland

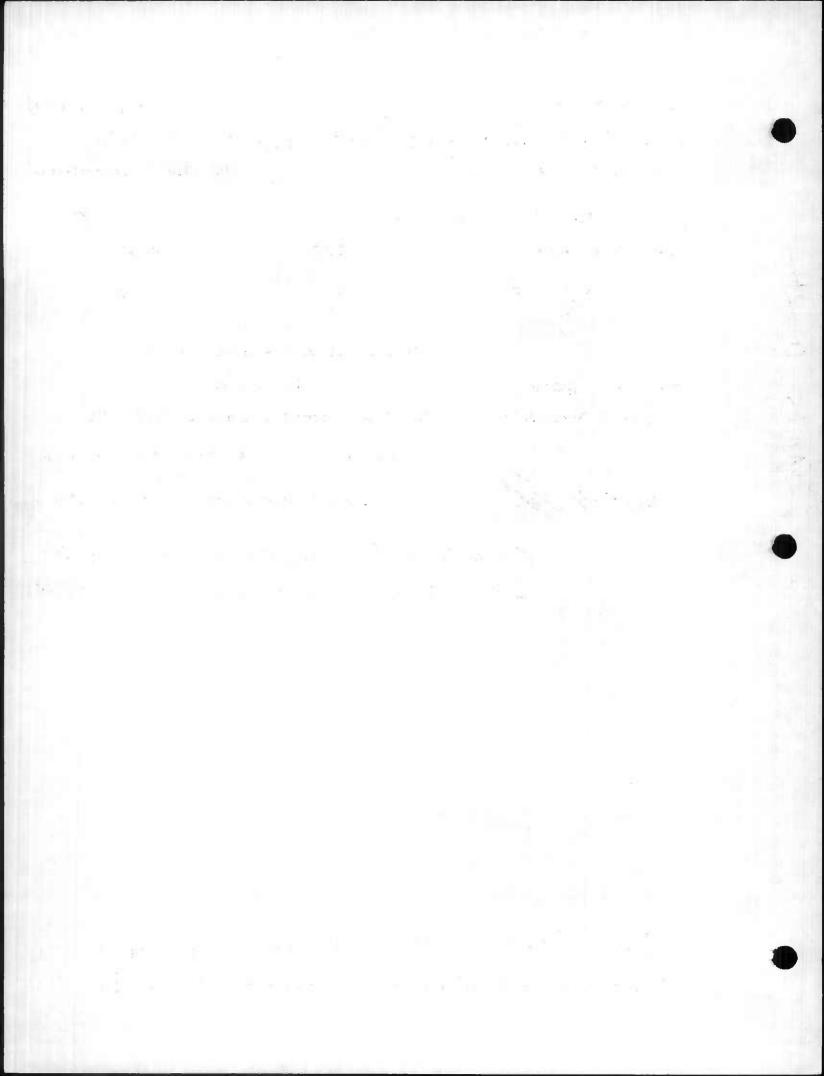
32. Registrer's Signeture

1999

State Registrar Julie

31. Dete filed (Month, Dey, Yeer)

MAR 9



1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day 03 **Physician** March CLIFTON R. NICHOLS /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Deeth Examiner Baltimore Citro Nicholas SINAI HOSPITAL If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Deys 10XM 20 F Yrs. 243-16-2198 77 07/29/1922 **Director** Usual Residence of Decadent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD N/A BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4806 HADDON AVENUE 21207 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 월 Yes 2 □ No 1941 -It Yes, Give 1945 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: Aq 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Chemical Corp. Known as Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Separator 12th 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Menta and Menta Edward Nichols Viola Sneed Lo 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) permit. Peges 1 end 2 Department of Health a Important: If Item 27 Is Valarie J. Dargan 4806 Haddon Avenue, B alto., MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 3 / 1 0 / 9 9 Dete 20c. Location - City or Town, State 20a. Method of Disposition 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from State Garrison Forest Vet. Cem. Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Injury Willie E. Howell, 21. Signature of Funeral Servica Licens 22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 eart talling the complications that cause on each in death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Death Cardiac Sudden

Examiner

physician and the bunal-tran

use as

Examiner

Physician/Medical

ð

Completed

To

Certification:

edical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury

Due to (or as a consequence of): fibrillation ventrico lar Due to (or as a consequence of): ARTERY DISEASE CORONARY Due to (or es a consequenca of): My ocar dial inforction

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible,

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 9 9 7 4 5 4

that initiated events resulting in deeth) Lest

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Cancer

24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed?

3. Time of Death

Birthplace (Stete or Foreign Country)

N. Carolina

10d. Inside City Limits

Interval Between Onset and Deeth

hour

1 hour

2 MONTHS

1 Yes 2 No

1 2 Yes 2 □ No

1999

U.S.A.

14. Race - American Indian,

Black

Biack, White, etc.

1153

25. Was case referred to medical 1 Pres 2 No Cre legaco Nospitei:

28e. Dete of Injury (Month, Dey Year)

1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

26. Place of Death (Check only one) 28c. injury at Work?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

1 Yea 2 No

Location (Streef end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only

27. Manner of Death

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and pieca, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, end due to the ceuse(s) and manner steted.

29b. Signeture and title of certifier Victor

5 ☐ Pending

Investigation

6 Could not be determined

29c. License number D29391

29d. Date signed (Month, Dey, Year) MARCH 3, 1999

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Victor jamin 1999 32. Registrar's Signature

Registrar

aftar death.

24 hours

To the Within 2

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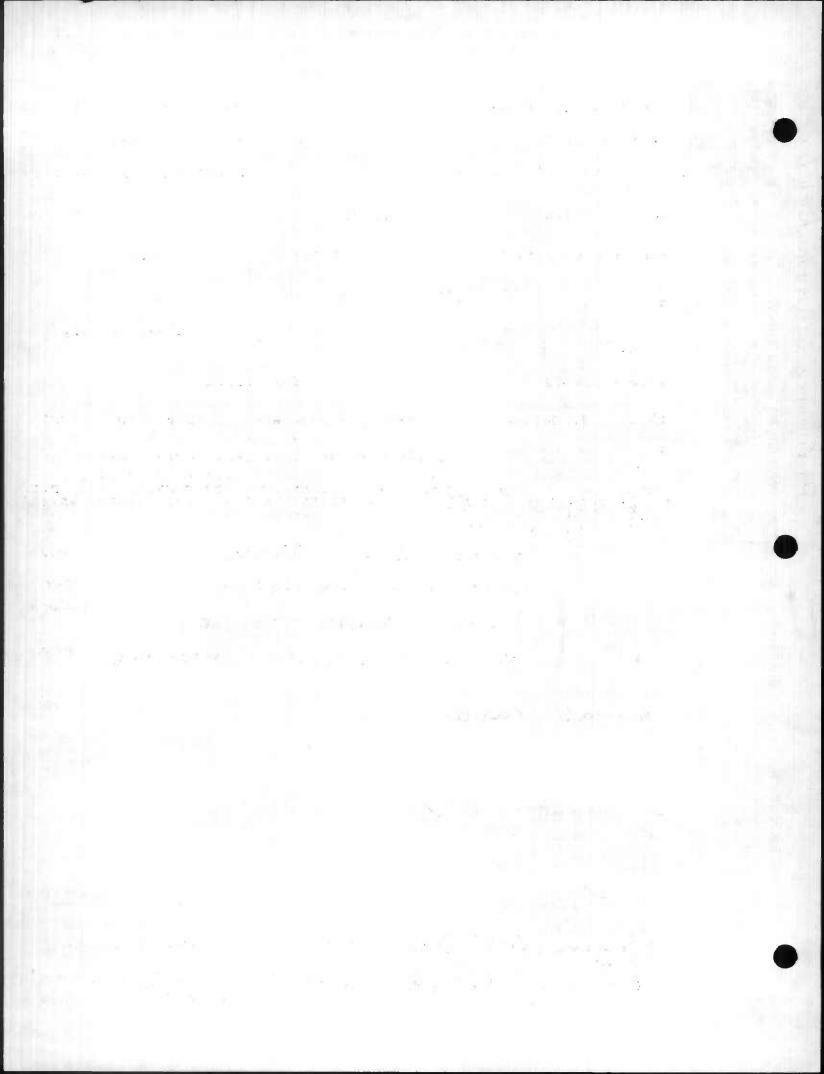
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completely

Division of Vital Records,

DHMH 16 Rev 6/95

1838 Greene Tree Road,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month Day Richard M. Nichols, Sr. MARCH 6, 1999 8:45 PM 4a Fecility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth SAINT JOSEPH MEDICAL CENTER TOWSON 5. Social Sacurity Number 6 Sax 7. Age (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foraign Country) 1☐M 2□F Min Months Deys Hours 4-11-1908 215-09-2494 90 Pennsylvania Usual Residence of Deceden 10a. Stata 10b. County 10c. City. Town or Location 10d Inside City Limits Maryland 1 ☐ Yes 2 ☑ No Baltimore Towson 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 302 E. Joppa Road, Apt 1310 21286 U. S. A. 12. Was Dacedant Ever In U.S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien, 11. Marital Status Black, White, etc. 1 ☑ Yas 2 ☐ NoWWII 1 Navar Married 2 Married 1 Yas X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collaga (1-4or 5+) Retail Sales K. Katz 18. Mothar's Name (First, Middle, Maidan Sumama) 17 Fathar's Name (First Middle Last) Roy M. Nichols Margaret Touhev 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informent's Name/Ralationship (Type, Print) Mr. Richard M. Nichols, Jr. 2833 Gateshead Court, Abingdon, Maryland 21009 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, State 20a. Method of Disposition cematary, cramatory or other placa) 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Druid Ridge Cemetery 3-10-99 Pikesville, Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the diseasa, or complications that causad the daeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. 1050 York Road, Towson, Md. 21204 Approximate Intarval Batween Onsat and Death Immediate Ceuse (Finel disease or condition rasulting in daath) el cola CU Sequantially list conditions, if eny, leading to immediate ceusa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Part II. Other afgnificant conditions contributing to death but not resulting in the underlying ceusa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nuknown 24b. Wara autopsy findings aveilable prior to complation of ceusa of daath? 24a. Was an autopsy OK minary de see 30 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medical 26. Place of Daath (Check only ona) axaminer? Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident

certificate be executed -tran burialphysician the USB BSU ed by the e signed b page 2 certificate director.

Physician

/Medical

Examiner

Funeral

Director

mast be notified at

than "natural", or items the Medical Examinar ma

Hygiene.

i. Pages 1 and 2 should be filed w tment of Health end Mental Hygier tant: If item 27 is marked other th lury or other traumatic event, the

permit. Page Department of Important: If any Injury or

Physician /Medical

Examiner

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medical

3 ☐ Suicida

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signatura end titla of certifiar

Directo

Funeral

p

Completed

Be

the Meryland

with

death

filed within 72 hours after

altimore, Maryland 21215-0020

Records, P.O. Box 68760. Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica filled in by 24 hours To the Hospi within 24 hour To the Funer completely fi

State Registrar

DANTONO

29c. License number

Certifying Physician: To the best of my knowledga, death occurred et the time, date and piece, and due to tha causa(s) and mannar es stated.

[2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, deta end place, and due to the ceuse(s) and mannar stated. 29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama end eddrass of person who complated ceusa of death (tam 23a) (Type, Print)

7401856er a.M.D.

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

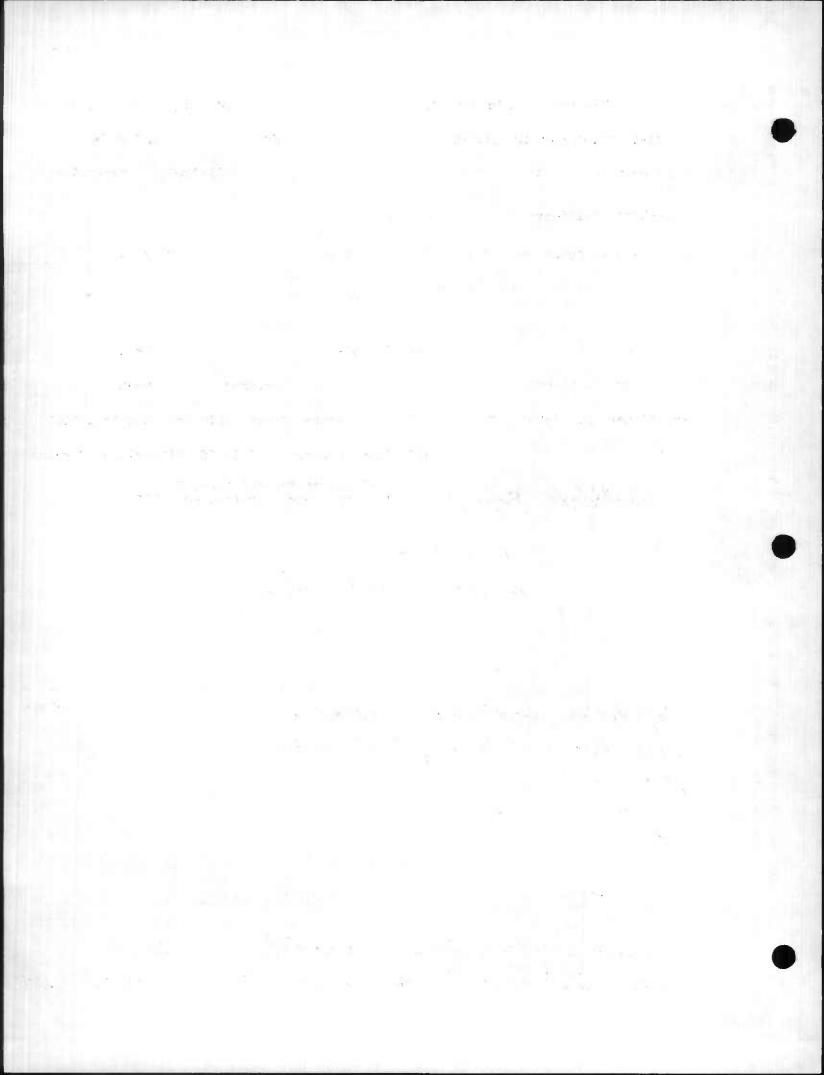
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31. Data filad (Month, Day, Year) MAR 0 9 1999

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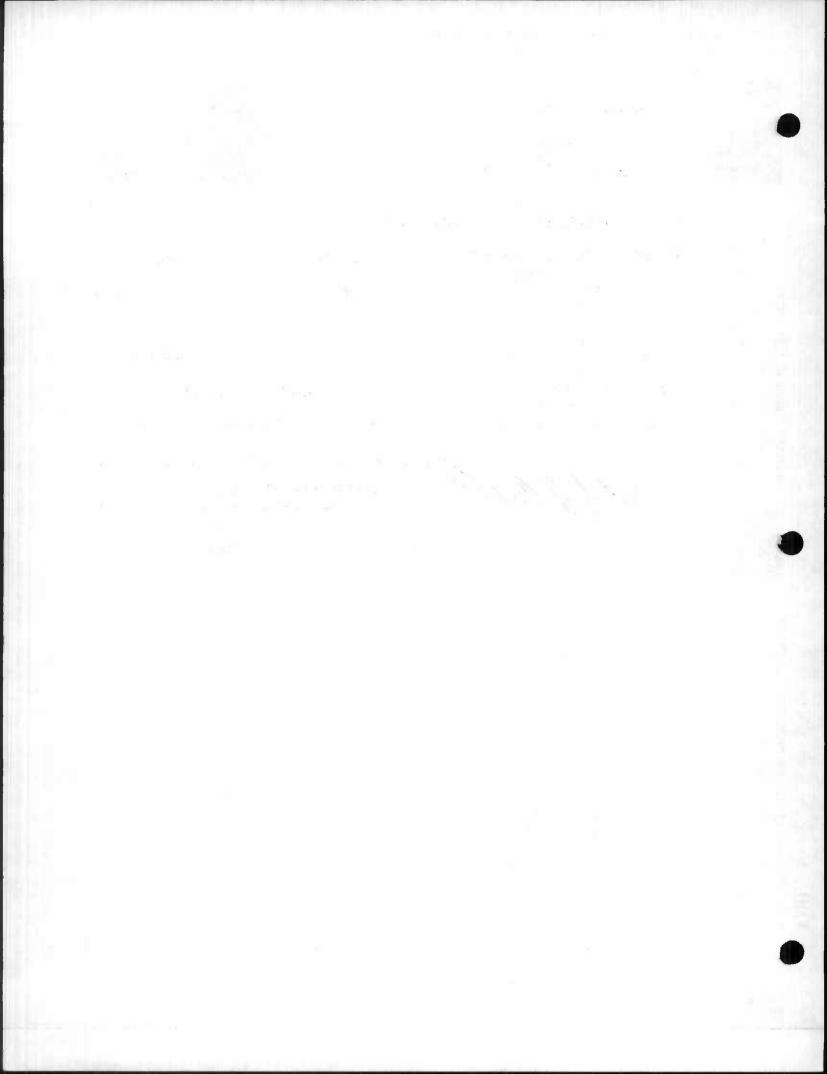
32. Ragistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 0 7 4 5

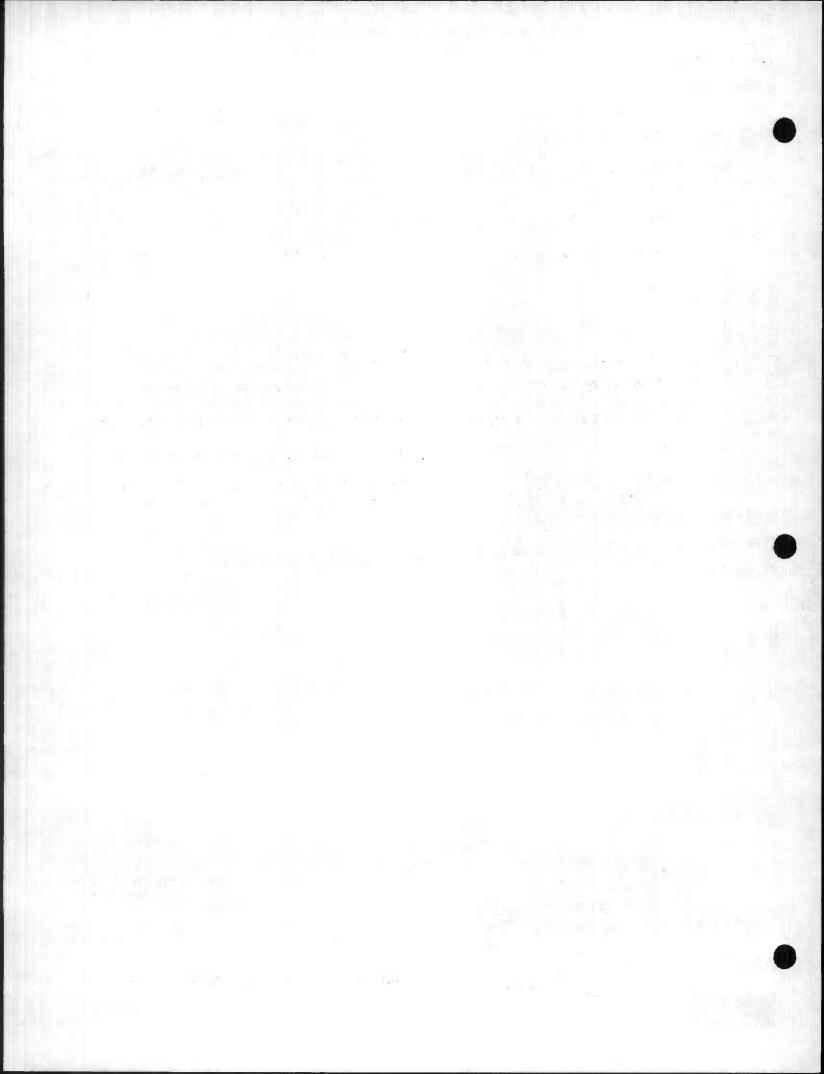
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	/Medi		Arthur Benj								Har	01	99	2020
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	Funeral Director		5. Sociel Security Number 199–30–6216 Usuel Residence of Decede		XM 2□F	Age (In yrs. 88	lest birthday Yrs.	Months	Deys			th by, Year) • 1911		nplece (State or Foreign untry) land
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	Men.	ţ	MD Ba	1timo:	re	Ca	tonsvi	11e						1 ☐ Yes 2 ☐ No
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	th wil	a	719 Maiden	Choice	e Lane #	BR608		2	122	28		USA		
21215-0020	and 2 should be filed within 72 hours after deeth with the Meryland asith end Mentai Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show ser traumatic event, irs Medical Examine man be notified at	by Funeral Director	11. Meritei Status 1 Never Married 2 3 Widowed 4 Divi		12. Wes Deced Armed Forc 1 Yes 2 If Yes, Give Yeer or Date	es? ₹No	I,S. 13.	Was Decede If Yes, speci 1 ☐ Yes 2		dispenic Origin? (Seen, Mexican, Puerl Specify:	specify Yes or No to Rican, etc.)) - 14.	Race - Amer Bieck, White	
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Maryland	d 2 sl th end 7 is n		19e. Informent's Neme/Rele			`	19b. Meli	ing Address	(Street	end Number or Ri	ural Route Numb	er, City or T	own, Stete, Z	^(ip Code) 21228
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altimore,			1 Burial 27 Creme 4 Donetion 5 Oth	tion 3 🗆 I	Removei from St	ate	cemetery, cre	metory or oth	her ple	1				
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	Discontinue		shock, or heart feilure.	List only o	ne ceuse on eed	h line.	n. Do not en	ter the mode	or ayır	ng, such es cardie	or respiretory e	rrest,	1	Approximete Interval Between Onset and Deeth
5	Physician /Medical		immediate Cause (Finei		C.+	- 22	- 110	60.11	۸	2 100	10001			
	Examiner		disease or condition resulting in death)		e. CEE				171	2 1/00	CAREN	1		3 days
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30,	icete be executed physicien and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	5	b	Due to (d	or es e conse	quence of):					1	
β, Box 68760,	The law requires that the death certificete be executed ate hes been signed by the ettending physicien and page 2 should be deteched for use es the burial-transit	-	that initiated events resulting in death) Lest	1	d	Due to (c	er es e conse	quence of):						
œ.	death e ette d for	Icla	Pert II. Other significent col	nditione co	ntributing to deat	h but not ree	ulting in the	inderlying co	ueo ai	uen in Part i	23h Did	tobacco un	contribute	to the cause of deeth?
P. 0.	res that the de signed by the e I be deteched f	Physician/	Total State againcent con	iditione co	nthouting to deat	n out not res	ding in the i	muenying ca	nza čiv	ven in raiti.		Yas 200		obably 4 Unknown
3, 5	s tha	by P										2921		Joseph 4 Guillian
Arthur Records, P.C	e law require hes been sig ge 2 should b	Completed										en eutopsy ormed?	6	Were sutopsy findings welleble prior to completion of cause of deeth?
		50									1 🗆	Yes 2 1	lo 1	☐ Yes 280 No
Th. Vital	ysician: The is certificate director, pag	Be	25. Wes case referred to me examiner?	-						26. Piece of Dec	eth (Check only	one)		
of V	0 0	P	1 ☐ Yes 2 ☑ No		Hospital: 1 🔀 inp		ER/Outpetie	nt 3□ DO/	Oth	ner: 4 🗆 Nursing H	lome 5 Resi	dence 6 [Other (Spec	elfy)
Nach	ing.	Certification:	2 Accident in	ending vestigation	28e. Dete of (Month,	injury Dey Year)	28b. Time of Injury	of 28	c. Injur Wor 1 🗆	ry et rk? Yes 2 □ No	28d. Describe	how injury o	ocurred	
	frechirect irect	Certific	3 ☐ Suicide 6 ☐ C 4 ☐ Homicide	ould not be etermined	28e. Piece of building	Injury - At h , etc. (Specif	ome, farm, st	reet, fectory,	office		28f. Location (City or To		um <i>ber or R</i> u	rel Route Number,
NAME	Hosp 4 hot Fune tely fi	edical	(Check only 2 Mac	tifying Phy lical Exami	ner: On the basi	s of examine	wledge, deet	h occurred el	the tir	me, dete end plece opinion, death occu	, end due to the	ceuse(s) en date end ple	d menner as	steted. to the cause(s)
X	To the Hospital of within 24 hours at To the Funeral D completely filled it	Med	one) 29b. Signeture end title of ce		end manne	steled.				se number				
	F ₹ F 8	-												o, Dey, Year)
			+ HOPE			LD				270?		in the	CH!	+,1999
	5		30. Name and address of pa	rson who co	ompleted cause		= 23e) (Type		9	DO CAT	and An	15 A	MT: A	1005
	Sta	te		(109) >	32. Reg	jetrer's Signa		~ ~ 1)	OU CAI	CIV III	C 12	14.11	NORE
	Registr		MAR	9 19	99	, en		/						



DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 0 7 4 5 7

SF	HARON O	SI	ETSKI				Cer	tificate	of L	Death		Reg. No.	0 1	
	Dhusiai		1. Decedent's Name	e (First, Middle, La	ist)						2. Date of D Month	eath Day	Yeer	3. Time of Death
	Physici /Medic Examin	al	4e Fecility Name (I	Rose Of not institution, give FOSTER AV	re street end nui				4	o. City, Town, or BALTIMO	MARCH Location of Des	6, 199	9	11:29 A
	Funeral Director		5. Social Security N 220 – 68 –		Sex 1□M 270 F	7. Age (In yrs 39	last birthday) Yrs.	If Under	1 Year Days	If Under 24 Hrs Hours Min	. (Month, E		Count	ece (Stete or Foreigr lry) d •
	ט		Usual Residence of			10- 02	7.							
	show	7	Md .	N/A			, Town or Lo						10	Od. tnside City Limits 1 □XYes 2 □ No
	the N	ecto	10e. Street and Nur				Balti	nore	Code			10g. Citizen of	What Count	
	with with	Funeral Director		Foster	Δνο			101. 2.10		1224				пут
	Jeath 22	era	11. Maritel Status	TODCCI	12. Was Deca	adent Ever in U,	S. 13. V	Vas Decede		1224 spanic Origin? (S n, Mexican, Puer	Specify Yes or N	US 10- 14. Rad	e - America	
21215-0020	d 2 should be filed within 72 hours after death with the Manylend Ih and Menial Hyglene. 7 Is marked other than "natural", or items 23a or 23a-f show traumatic event, the Medical Examinar must be notified at	by	1 Never Marri 3 Widowed	ied 2 Married	Armed For 1 Yes If Yes, Given Year or D	2 🕅 No /e		Yes, speci		Specify:	to Rican, etc.)		ck, White, e y: Whi	
5-0	72 hc natur	Completed	(Spec	15. Decedent's E	ducation ede completed)		16e. Deced	ent's Usuai kind of work	Occupa done d	tion uring most of wo	orking	16b. Kind of B	usiness/Ind	ustry
121	within the.	mpi	Elementery/Seco	ndary (0-12)	College (1	I-4or 5+)						Federa	al Co	N 1 40
CA	Hygie ther ther	CO	12 yr	S . (First, Middle, Lest	4 yr	s.	Gr	apnı	C A	rtist 18. Mother's Ne	me (First, Middl	e, Malden Surnan) V L
Maryland	should be nd Mental marked o	To Be		d Osiet								rkowski		
lan	and A mails man		19a. informant's Na					-				ber, City or Town		
	C 7 0 =		Edward (i fat							ore Md.		
Baltimore,	Pages 1 a ment of Hea ant: If flom ury or othe			oosition Cremetion 3 [5 Other (Special			leca of Dispo emetery, cren cred			e) f Jesus	Date 3 / 1 (20c. Location Dund		wn, State
Balt	Depart Depart Import any inj		21. Signature of Fu	riefai Sarvice Lice	E)		Co 7	Name and	l Addres	s of Facility Funeral Lers Po	L Home	Of Dun	dalk	
	Physician /Medical Examiner	ner	tmmediate Cause (disease or condition resulting in death)	Final	e.	aused the death ach line.	force	he	of dying	such as cardla	c or respiratory	arrest,		Approximate Interval Between Onset and Deeth
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the buriel-transit	n/Medical Examiner	Sequentially list cor if eny, leading to im cause. Enter Unde Cause (Diseese or that initieted events resulting in death) I		b c d		r es a conseq as a conseq							
P.O. Bo	ires thet the death cer signed by the attendir d be detached for use	Physician/	Part fl. Other eignifi	icant conditions	contributing to de	eath but not resi	ulting In the u	nderlying ca	use give	en in Part I.				the cause of death
Records, F	To the Hospital or Attending Physician: The law requires the Within 24 hours after described. Within 24 hours after described within 50 hours after described within 50 hours after described with 50 hours after the funeral director, page 2 should be decompletely filled in by the funeral director, page 2 should be de	Completed by F		Š.							24a. We	es an autopsy formed?	ava	ore autopsy findings allable prior to appletion of cause death?
œ _	The I	Com									18	ðYes 2□No	1,2	Oyes 2□ No
Division of Vital	entific entific ector,	Be	25. Wes case referrexaminer?	red to medical					1.00		eth (Check only	one)		
5	Physician: this certific ral director,	2	XIX Yes 2□			npatient 2				4 Li Nursing	_	sidenca 6 □Oth)
L C	Ing P	lon	27. Manner of Death 1 ☐ Naturel	5 Pending		of Injury th, Dey Year)	28b. Time of Injury		Bc. Injury Work	at ? ∕es 2)kaNo	Should Should	e how injury occur	red	
Sign	Attending or death. ector: After by the fune	Icat	2 ☐ Accident 3 ☐ Sulcide	Investigation	e On Diago	of Injury - At he	WWK			es ZINSINO	28f. Location	(Street end Num	ber or Rura	l Route Number.
<u>≥</u>	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	4 Homicide	determined	bulldi	ng, etc. (Specif)	1)	me			38U	foster /	he,	Balto
	Hosp 24 hou Fune stely fi	edicai	29a. Certifier (Check only one)	1☐ Certifying Pt XX Medicat Exa	miner: On the ba									
	To the Hospital within 24 hours To the Funeral completely filled	Me	29b. Signature and	title of cartific)		29c.		number C.M.E		29d. Date signe MARCH		
			30. Name end	essipi person wind	completed caus				eet,	Baltimo	ore, Mar	yland 2	1201	
	Sta Registr		31. Dete filed (Mont	if bay, Year)	32. R	egistrar's Signa	ture	,						
DHI	MH 16 Ray 6/9		MAR	2 1000	10101	-	· My	south	/					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death Month **Physician** Margaret M. O'Connor March 5 1999 8:00 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care Ruxton Towson Baltimore tf Undar 24 Hrs. 5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) **Funeral** Deys 1□M 25 Hours Months Yrs. 097-03-7549 83 Director Oct. 25 1915 New York Usual Residence of Decadent 10a. Stete 10c. City. Town or Location 10d. Inside City Limits 28a-f show be notified at 1 ☐ Yes 2 ☐ No Directoi MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 2312 Foxley Road 21093 USA "natural", or items 23a filed within 72 hours effer death w Hygiene. other than "natural", or itema 23a ent, the Mexical Experience must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 15 No ff Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indian. 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Merried altimore. Maryland 21215-0020 1 Yes 2 No Specify: White Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Paper Co. n/a Packer permit. Pages 1 end 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked othe any Injury or other treumatic events. 18. Mothar's Nama (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Edward O'Connor Mary Bales 2 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Pat Bussey/Niece 2312 Foxley Rd., Timonium, MD 21093 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete St. Mary's Cemetery 3/13/99 Flushing, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Nema and Address of Facility Lemmon Funeral Home Michael Flagle 10 W. Padonia Rd., Timonium, MD 21093 23a. PertT. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximete Intervel Batween Onset end Death **Physician** /Medical tmmediate Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner death certificate be asscuted Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last and Due to (or es a consequence of): physician s the buriel Box 68760. Physician/Medical Due to (or es a consequance of): attending p Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown à been signed to should be det Records, by 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 No 1 Yes 2 INO certificate Division of Vital 25. Was case rafarred to medical examiner? 26. Placa of Death (Check only ona) Be Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this 28d. Describe how injury occurred 27. Menner of Death Certification: 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? e Hospital or Attending P n 24 hours after death. e Funeral Director: After t After 1. Neturel 5 Pending investigation 1 TYes 2 TNo 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicida 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

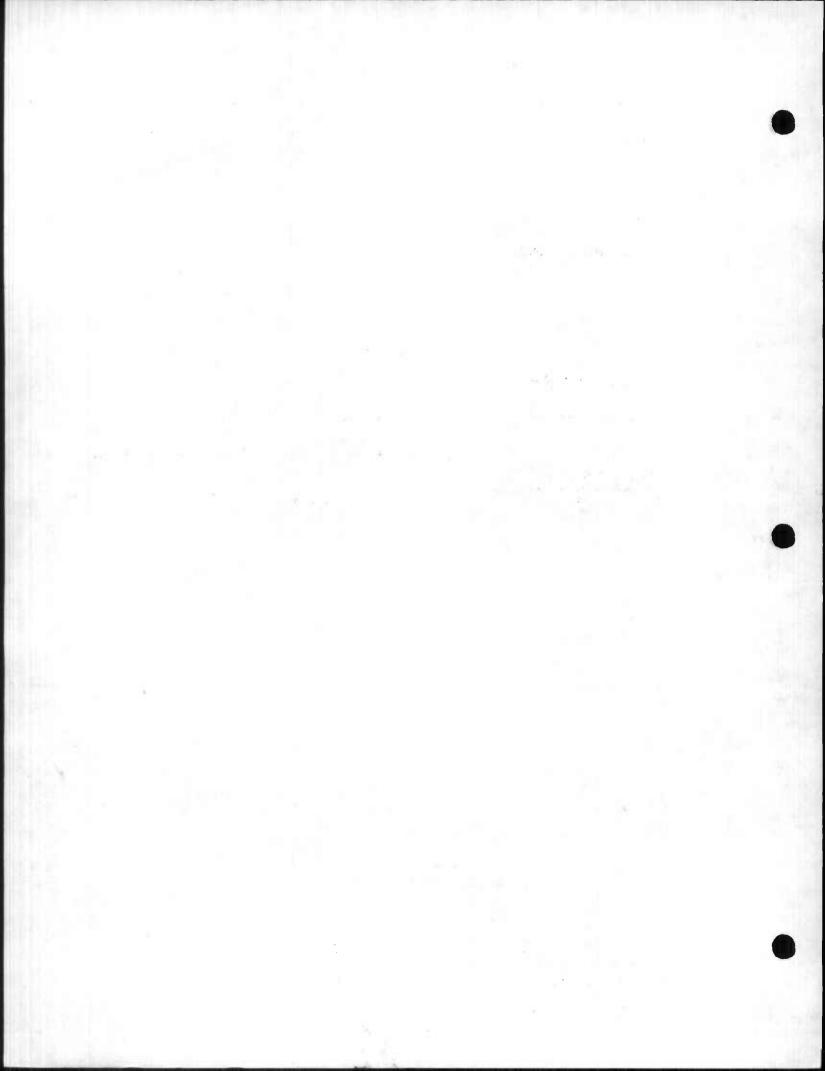
2 Medical Examiner: On the bestsor axamination and/or invastigation, in my opinion, deeth occurred at the time; date and place, and due to the cause(s) edical (Check only 29b. Signature and title of certific 29d Date signed (Month, Day, Year) 29c. License number REG) 30. Name and address of person who complated cause of death (ttem 23e) (Type, Print) Mohammed Rahnama, M.D. 17 Fontana Lane, Suite 105, Balto., MD 21237

31. Date filed (Month, Dey, Year) State Registrar

MAR 0 9 1999

32. Registrer's Signeture

porto



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9:20A.M. Milton Petty Wagner March 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Rosedale Franklin Square Hospital Canter Baltimore If Under 24 Hrs. If Undar 1 Yaar 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 10 M 2 F Months Days Hours Min 81 Yrs 203-03-8350 July 10, 1917 Pennsylvania Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? 21236 25 Arlen Road, Apt. H U.S.A. 12. Wes Decedant Ever in U,S. Armed Forces? 1 (X/Yes 2 □ No If Yes, Give Yaar or Datas: WW I I 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Sfatus Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Construction Foreman 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Hannah Decker John Francis Petty 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 25 Arlen Rd., Apt. H, Baltimore, MD Mrs. Toni Bentley (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burlai 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 3/10/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Addrass of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21. Signature of Funaral Servica Licensee Buin a. Willem 21236 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. . Congestive Heart Failure Immediate Cause (Final disease or condition resulting In death) 48 Hours Coronary Artery Disease Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 23b. Did tobacco usa contributa to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Diabetes Mellitus Type 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide

Examiner requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760. for use as s certificata has b funeral 5

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

tem 27 is marked other than "natural", or flems 23s or other traumatic event, the Modical Example of must be

Important: If tem 27 is n any injury or other traumonce.

Physician

/Medicai

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

Pages 1 and 2 should be filed within nent of Health and Mental Hygiane.

Directo

Funeral

by

Completed

72 hours after death with the Maryland

PETTY, Milton W.

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

Registrar

29b. Signatura and titla of cartifier 12 hoese in 29c. Licansa number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

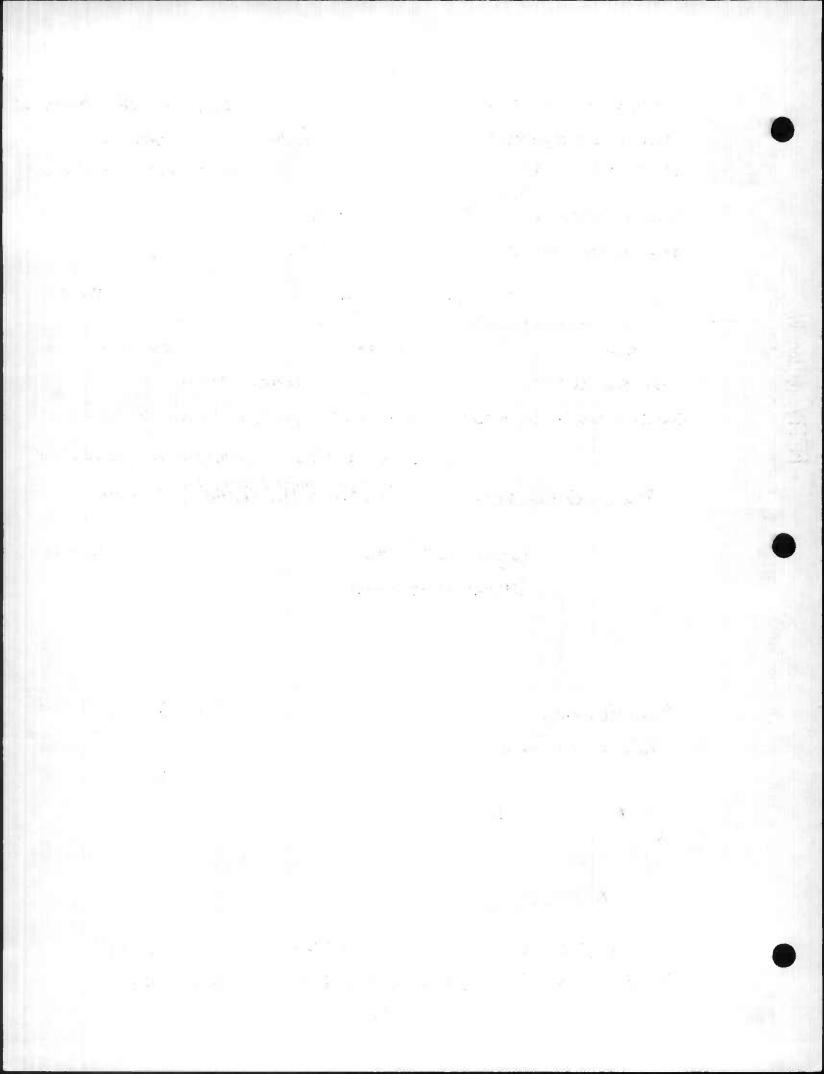
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

45789

Wilbur R. Rogse, 9000 Franklin Square Drive, Baltimore, Maryland

31. Dete filed (Month, Day, Year) 32 Registrar's Signature MAR 0 9 1999 Comerca



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

		State of Ma	aryland / I	Department Certificate	of Health and of Death		eney y	0746	U
	1. Decedent's Name (First, Middle, I	Last)				2. Data of Death			of Death
ician dical		Thelma W.	Phillip	08		March	Day 5,	Y999 5:4	5 A.
niner	4 a. E = -2126 - 51	giva straat and number)			4b. City, Town, or	Location of Death	4c. County	of Death	
	Stella Maris				Towso		Bal	timore	
al or	275-26-2252		e (In yrs. lest bii 2		Yaar If Under 24 Hrs Days Hours Min	8. Date of Birth (Month, Dey, Dec. 17	Year) 1916	9. Birthpiace (State Country) DX	e of Fore Stri
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10d. insida	City Lim
ō	Maryland Ha	rford		Forrest	4:00				es 2)()
Director	10e. Street and Number	7007ta		10f. Zip (10	g. Citizen of W	hat Country?	
ā	927 Delray Drive			1	21050			S. A.	
Funeral	11. Marital Status	12. Was Decedant I	Ever in U,S.	13. Was Decede	nt of Hispanic Origin? (5	Specify Yes or No-		- American Indian.	
FUT	1 Never Married 2 Married		ło	If Yes, spacif	y Cuban, Mexican, Puer	to Rican, etc.)		k, White, etc.	
À	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yas 2	No Specify:		Specify:	white	
ted	15. Decadent's	Education	16a	Decedent's Usual	Occupation	1 dring	6b. Kind of Bus	siness/Industry	
Be Completed	(Specify only highest g	rede completed) College (1-4or 5	+)	life. DO NOT use	done during most of wo retired)	erking			
Con		1 Year		Executive	Secretary		Board o	of Educat	ion
Be	17. Father's Name (First, Middla, Las	st)				ma (First, Middle, M		a)	
2					Gold	lie B. Rus	sell		
	19a, informant's Name/Relationship	(Type, Print)	196	. Mailing Address (Street end Number or A	ural Route Number,	City or Town,	State, Zip Code)	
	Virginia Lee Bro 20a. Method of Disposition 1 □ Burial 2 🕱 Cremation 3 4 □ Donation 5 □ Other (Spec	Removal from State	20b. Place o cemete	f Disposition (Nemerly, cremetory or oth			Dc. Location - 0	City or Town, State	
	21. Signature of Funeral Service Lice		orcen						Lana
	1-1/11	111		Schumu	Address of Facility NER Funeral	Home of	Bel Air	i, Inc.	
n il	23a. Pert1. Enter the disease, or co shock, or haart failure. List onl			not enter the mode		c or respiratory аггез		Approxim Interval B Onset an	nate Batwaan
miner	disaasa or condition resulting in death)			consequence of):	monary Dise	ease			
Exa	Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying	b	Due to (or as a	consequence of):					
Medica	that initiated events resulting in death) Last	c	Due to (or as a	consequenca of):			_		
Physician/Medical	Part ii. Other algnificant conditiona	contributing to death bu	ut not resulting in	n the underlying cau	se given in Part i.	23b. Dld tob	acco use con	tribute to the caus	e of dea
by Ph						1 🗆 Yes	B 2□ No	3 Probably 4	K) Unkn
						24a. Was an perform		24b. Were autops available prio completion o of death?	or to
pieted						1 ☐ Yes	2 X No	1 ☐ Yes 2	□ No
ompleted					26 Place of De	ath (Check only one			
le Completed	25. Was casa referred to medical	Hospital:	nt 2□EB/Ou	utpatient 3 DOA	Other:	Home 5 Residen		(Specify) HOS	PICE
Be	examiner?				c. Injury at Work?	28d. Describe how		1-1-1/	- 20.
To Be	examiner? 1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending	28a. Date of injur (Month, Dey					M 1 Yes 2 No		
To Be	examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of injur (Month, Dey	Year) i		1 ☐ Yes 2 ☐ No	28f. Location (Stre City or Town,	eet end Numbe Stete)	er or Rurel Route Nu	um <i>ber</i> ,
Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident	28a. Date of injur (Month, Dey	iry - At home, fa . (Specify) If my knowledge exemination an	M arm, street, factory,	1 ☐ Yes 2 ☐ No office the time, dete end plece	City or Town,	Stete)	nner as stated.	
To Be	examiner? 1	28a. Date of injur (Month, Dey de de de de de de de de de de de de de	iry - At home, fa . (Specify) If my knowledge exemination an	M arm, street, factory, s, death occurred at d/or investigation, in	1 ☐ Yes 2 ☐ No office the time, dete end plece	City or Town, a, end due to the cau urred at the time, dat	Stete) use(s) and mare and piaca, a	nner as stated.	e(s)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD

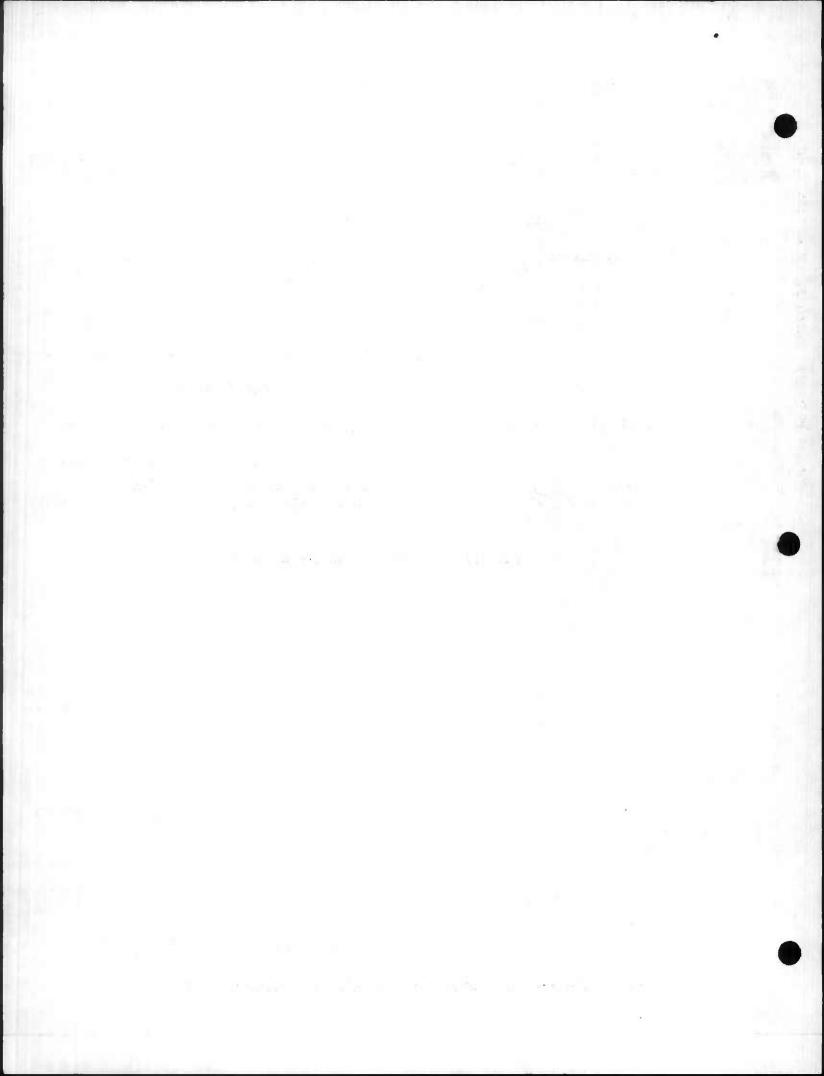
31. Date filed (Month, Dey, Year) State

MAR 0 9 1999

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2300 DULANEY VALLEY RD. TIMONIUM, MD 21093
32. Registrar's Signature



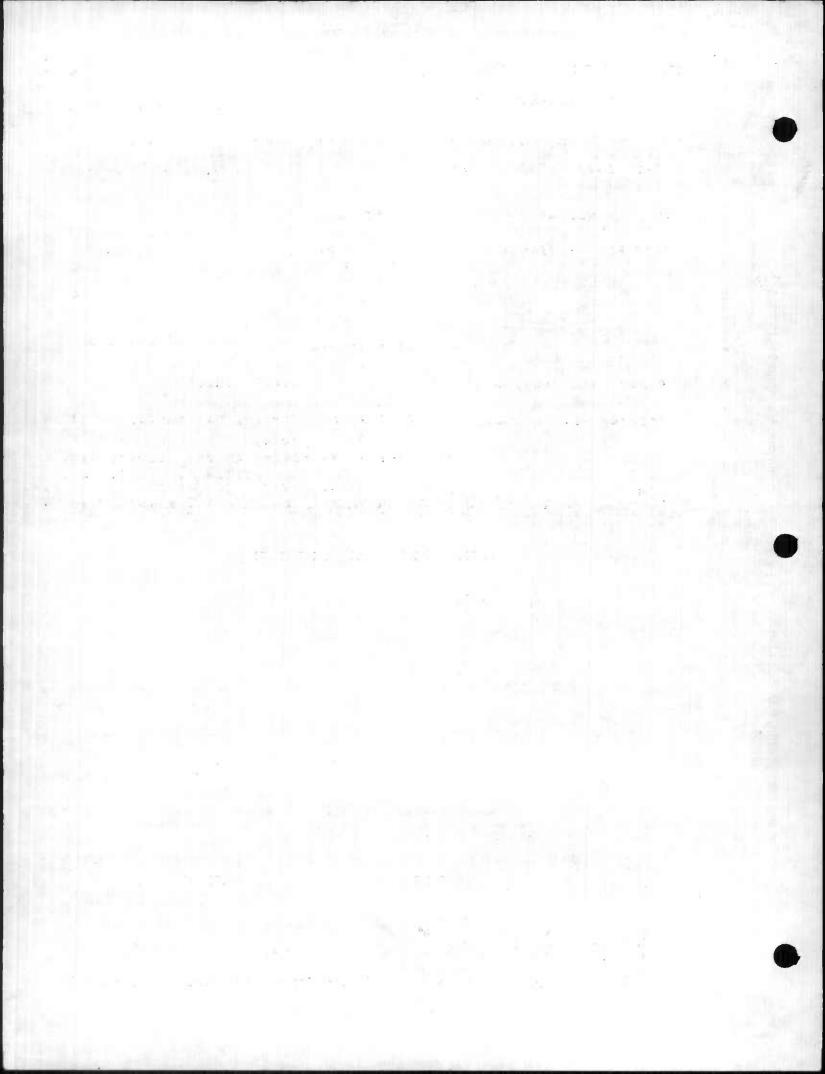
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rd.	Pinckney Jr	State of Maryland / Department of Health and Mental 28A-F PER MEO G769 Certificate of Death	Hygiene 00	0716
	ITEMS: #23 PART I, 27,	28A-F PER MEO G769 Certificate of Death	Reg. No.	0140

	Decedent's Nan	ne (First, Middle, Las								2. Dete of De		V	3. Tima of De	eth
ician	EDWA	RD PINC	KNEY, JR	2 .						Month	Dey 02. 199	Year	11:30	7 1
dical niner	4e Fecility Neme	(If not institution, give	e street end number))			4	b. City, To	wn, or Lo	ocation of Deel		y of Death	المعالم	Hal
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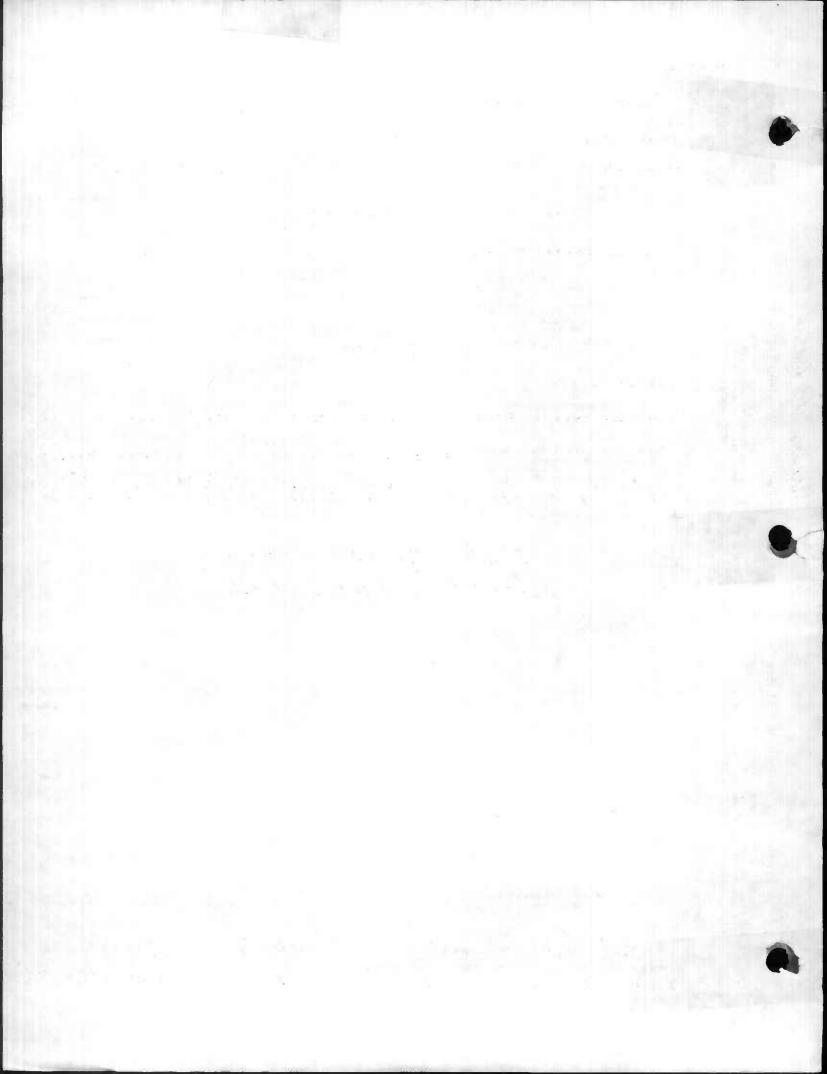
State Registrar

111 Penn Street, Baltimore, Maryland 21201



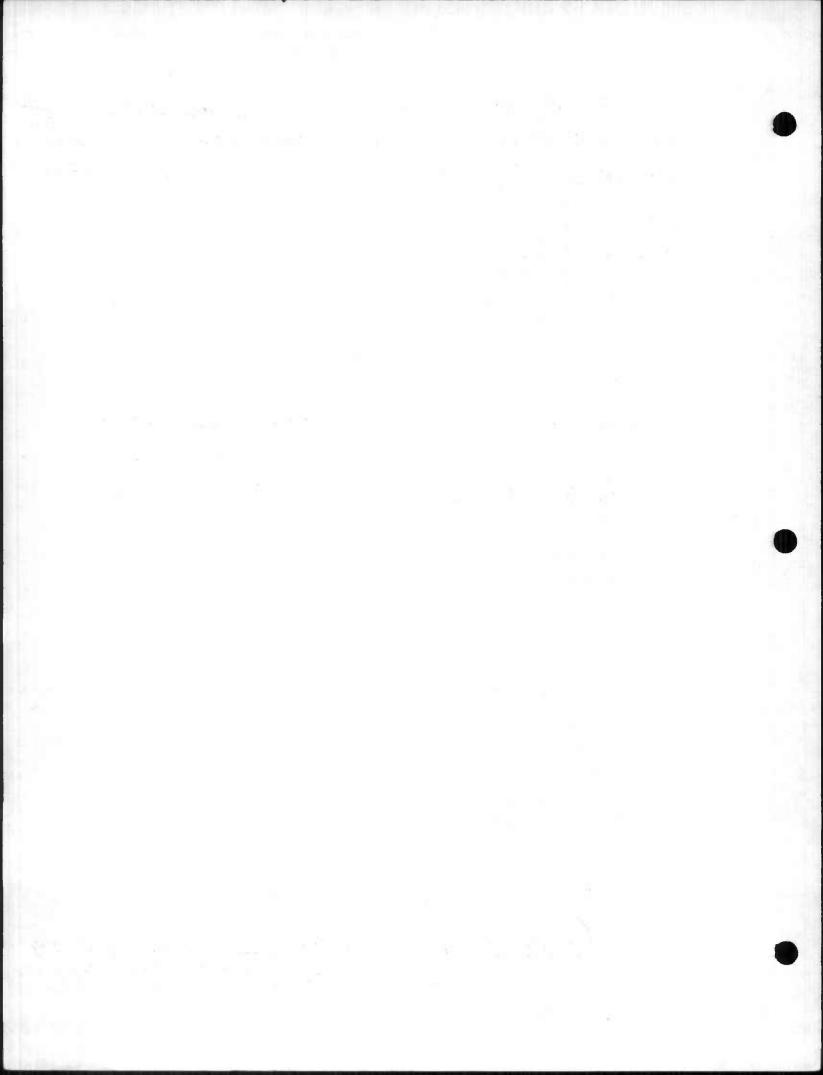
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State Registrar



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Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after comparation of Heelih and Mental Hygiena. Important: if Item 27 is marked other than "natural; or item any Injury or other traumetic event, it as Hedical Evant

Baltimore, Maryland 21215-0020

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Examiner physician and the burial-transit peen has

Box 68760 Physician/Medical Division of Vital Records, P.O. þ Completed or Attanding Physician: aftar death. Director: After this certific Be To Certification:

> Medical completaly To the To the I State Registrar

ARCHANIA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Archana

MAR 9

1 Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

5 Pending investigation

6 Could not be determined

K SHYAMSUN DER, HARBOR HOSPITAL CENTER, BALTIMORE, MARYLAND 32. Registrar's Signature

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Shyamsmola, MD

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Tyes 2 No

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MARCH 3, 1999

DHMH 16 Rev 6/95

Hospital 24 hours a 24 hours a

Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 07465 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month Mary Jane Roberts March 1999 9:02 PM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs 8. Dete of Birth (Month, Dey, Year) APR 24, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Deys 1□M 25 F 1919 217-07-9702 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 XNo Maryland Baltimore Dunda1k 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Beach Drive 21222 USA 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decadent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Status Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 X Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Cashier Convenience Store 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Stephen Crane UNK. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances I. Sprouse / daughter 8016 Grayhaven Rd. 21222 Dundalk, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 03/09/99 Baltimore, MD 21. Signeture of Foneral Service Licensee MC Dawn F. Mc Donald Cremation Society of MD, Inc. Donald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in deeth) Hrrythme Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to 24a. Wes en eutopsy completion of cause of deeth? 1□ Yes 2□ No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how Injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 BNatural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) end menner stated.

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Physician

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Funeral

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> State Registrar

29b. Signature and title of certifier

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29c. License number D314

29d. Dete signed (Month, Day, Year)

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

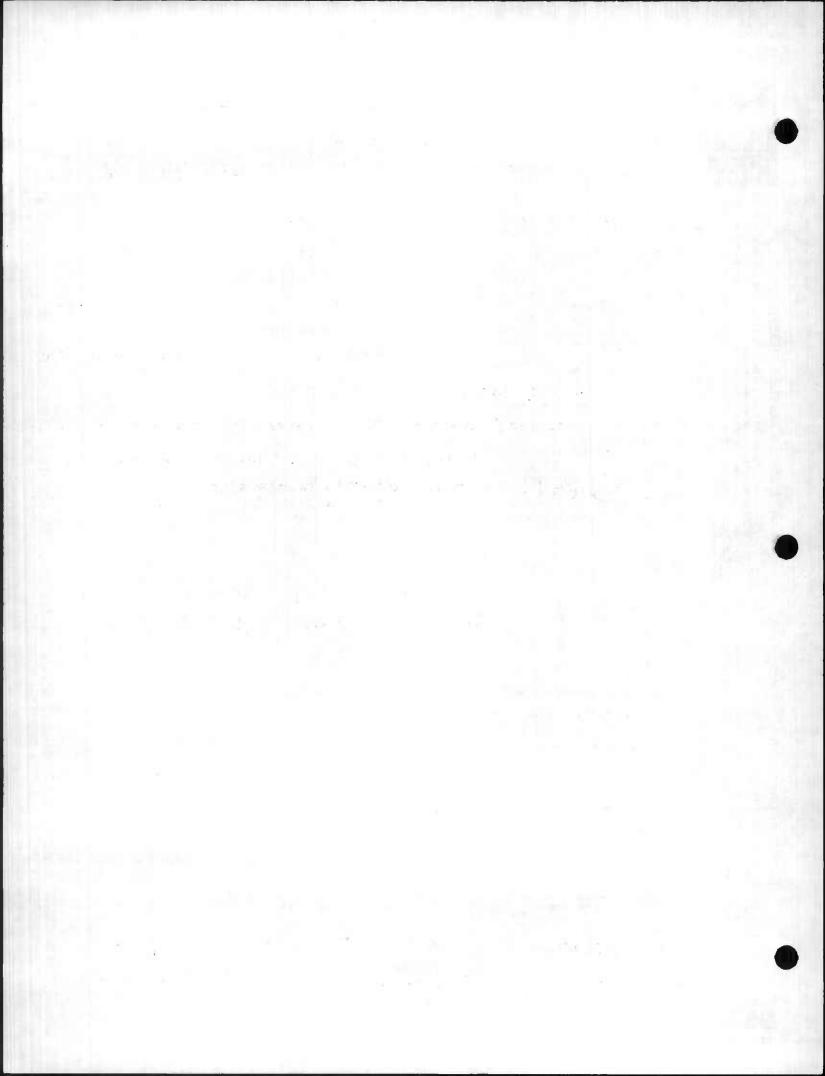
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32. Registrar's Signeture

31. Dete filed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Rascol Ether 12: 25 ANY 3 /Medical 4a. Feclity Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Yeer | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** Months 1 M 2 VF 069-38-7473 94 Yrs. Director APR. 10. 1904 Hungary Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at MD Howard Elkridge 1 Yes 2 XNo Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or itams 23a or 5950 Old Washington Rd. 21075 USA death Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. filed within 72 hours after Hygiene. wher than "natural", or ita 1 ☐ Yes 2 🕅 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 X No þ Specify: white 3 X Widowed 4 Divorcad Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Haalh end Mentel Hygien Important: If Itam 27 is marked other than any injury or other traumatic avant. 8 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) John Sturman Margaret (Unobtainable) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5950 Old Washington Rd., Elkridge, Md. Vilma A. Hopkins - daughter 21075 20e. Method of Disposition

1 □ Burial 2 □ Cremetion 3 □ Removel from Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 3/5/99 Lake Ron Kon Koma Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Long Island, New York ^{22. Neme end Address of Feclify} Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 21. Signeture of Funeral Service Licensee Tregur 7250 Washington Blvd., Elkridge, Md. nomos 23e. Pert 1. Enter the disease, or complications that contend the death. Do not enter the mode of dying, such as cardlec or respiretory errest shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ew days **Examiner** Examiner ettanding physician and for use es the bunal-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): certificate be execu Due to (or es e consequenca of): P.O. Box 68760, monde Physician/Medical sementia Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? thysulderni 2 No 1 Yes 2 No 1 Yes 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Neturel 5 Pending Investigation n 24 hours efter deeth.

Funeral Diractor: After detaily filled in by the fur 2 Accident 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signeture end title of certified 29c. License number 29d. Dete signed (Month, Day, Year) Kaya MD D27541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLETHA RAJA 4367 Hollins Ferry Rd Baltonone MD-21227 4367 32. Registrer's Signeture State

Registrar

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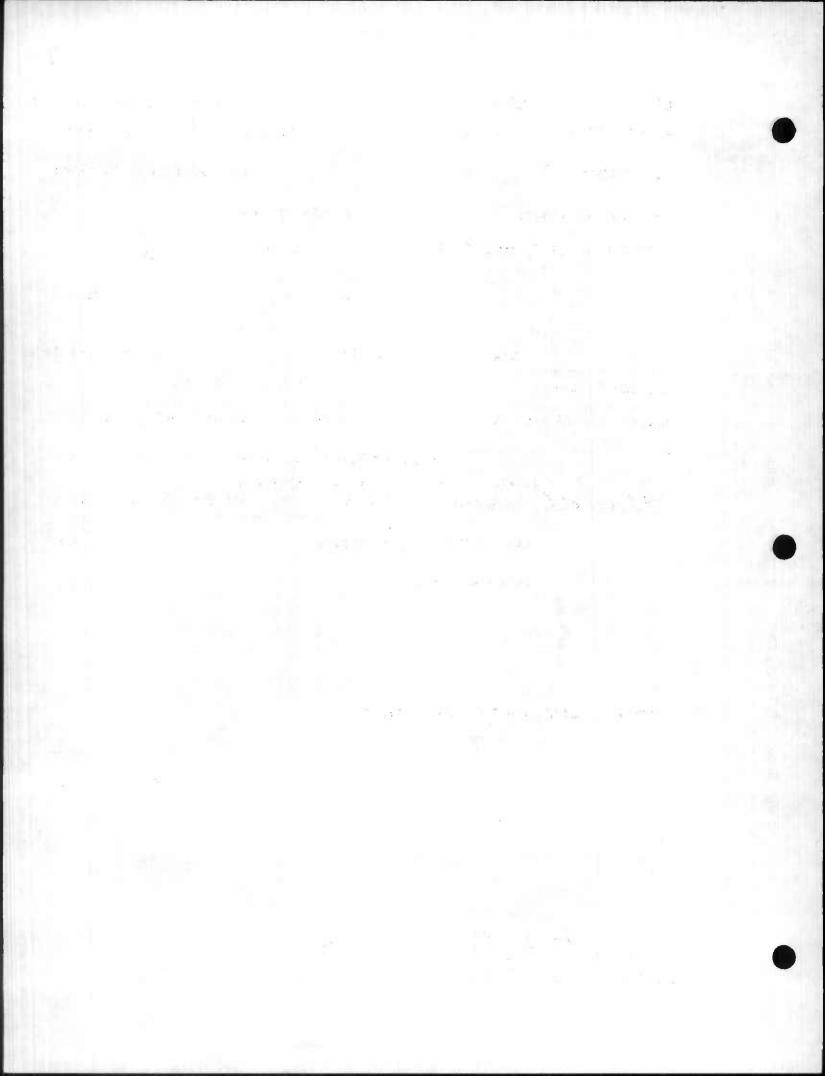
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month ARCH Day 4, 1999 **Physician** CARL Η. REEDER 10:25 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a Facility Nama (If not institution, give street and number) Examiner H Undar 1 Yaar H Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 15, 1914 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral X**□M 2□F Mary land Yrs. 213-07-2983 84 Director Usual Rasidance of Decedant with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits r than "naturel", or items 23s or 28s-f show the Wed call Examiner must be notified at Baltimore County Maryland Baltimore 1 ☐ Yas 2 No Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 21234 8820 Walther Blvd. Apt. #1213 USA death Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes X2 ☐ No If Yas, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indien. 11. Marital Stetus permit. Pages 1 and 2 should be filled within 72 hours affar to Department of Health and Mantal Hygiana. Important: If Itam 27 is marked other than "naturel", or Item any Injury or other treumatic event, the warterer, or Item and Bodge. Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 Yes XXNo Specify: White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 Yrs. Bethlehem Steel Corp. N/A Electrician 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Elizabeth Gercke Charles A. Reeder 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 9914 Marylynn Rd. Perry Hall, Md. 21128 Albert Zorn (Son-in-law) 20b. Place of Disposition (Nama of cematery, crematory or other place) Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition X Burial 2 Cramation 3 Ramoval from Stata Gardens of Faith Cem. 3-8-99 Baltimore, Maryland 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funarai Sarvice Licensae 22. Name and Address of Facility Home Lassann Funeral Home 7401 Belair Rd. Baltimore, Maryland Classalm 21236 Part 1. Entar tha diseasa, or complications thet ceused the death. Do not anter the mode of dying, such as cerdiec or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** GASTROINTESTINAL BLEED DAYS /Medical Immediata Causa (Final disaasa or condition rasulting In death) Examiner DUODENAL ULCER DAYS Examiner Tha law requires thet tha daeth cartificata be executed physician end s tha burief-transit Sequantially list conditions, if eny, leading to immadiata ceusa. Enter Underlying Causa (Disaasa or injury that initiatad avants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequance of) ed by the a 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying course given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE by 24b. Wara autopsy findings aveilabla prior to completion of ceuse of death? been si 24a. Wes an eutopsy performed? Completed page 2 s 1 Yas 2 No 1 ☐ Yas 2 No certificeta or Attending Physician; director, 25. Was cese raferrad to medical axaminar? Be 28. Plece of Death (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) Certification: To 1 ☐ Yes 2√ No ty Inpatient 2 □ ER/Outpatient 3 □ DOA this funaral 27. Mennar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Aftar 1 Netural 2 Accident 5 Pending To the Hospital or Attendir within 24 hours eftar death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yas 2 ☐ No Invastigation 6 Could not be 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida TC Cartifying Physician: To the best of my knowledga, daath occurred at tha tima, data and piace, and dua to tha ceusa(s) and mannar es stated.

2 Medical Examinar: On the basis of examination and/or invastigetion, in my opinion, daath occurred at tha tima, data and place, and dua to the causa(s) end mannar stated. Medical 29a. Cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 24034 0 30. Nama and addrass of person with complated ceuse of death (Item 23e) (Type, Print)
TIMOTHY LOW, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Data filad (Month, Day, Year) 32, Ragistrar's Signature

DHMH 16 Rev 6/95

Registrar

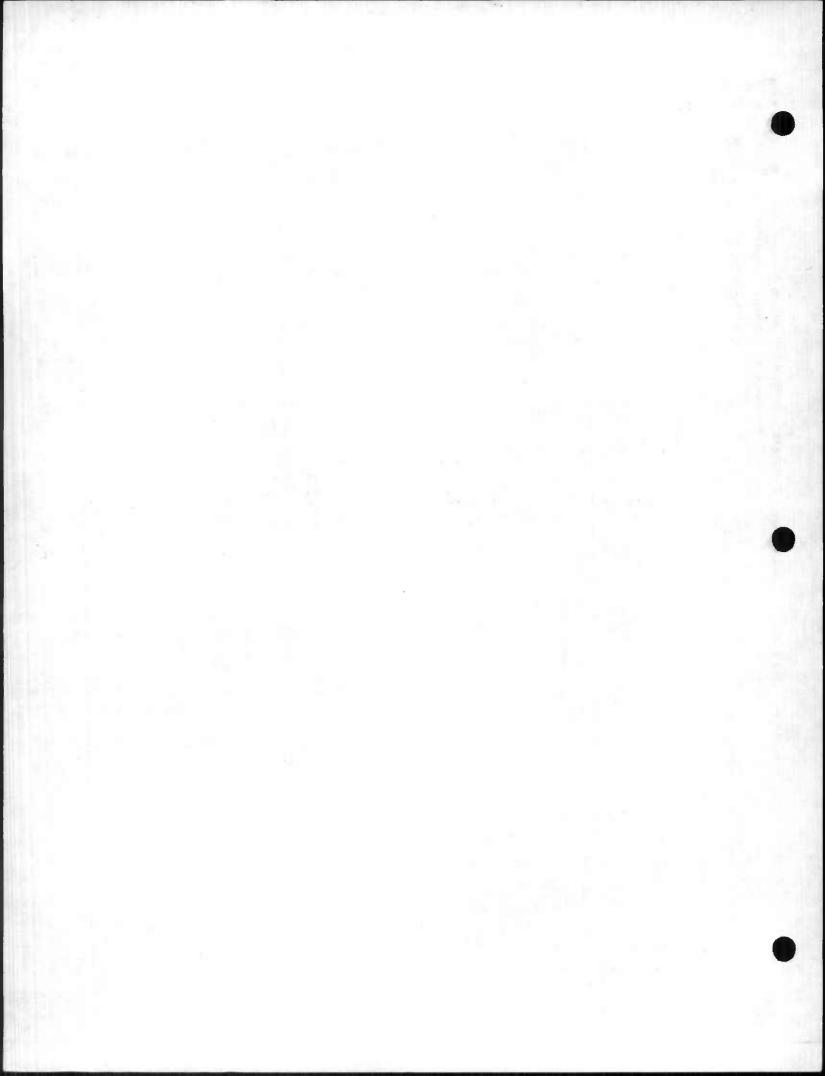
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State of Maryland / Department of Health and Mental Hygiene 0 0 0 7 1

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I Director	10e. St	reet and Number 00 Vantage	Point	t Rd.		10	f. Zip Code 210	14		10g. Citizen of V	What Country?
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (Item 29d Per PHY FilmG769 3-12-99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** March 6, 1999 9:30 pm Elfriede Radek /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Ivy Hall Geriatric Center Baltimore Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1 M 2 € F Months Deys 219-32-8529 Yrs. 86 Nov. 09, 1912 Germany **Director** Usual Residence of Decedent the Merylend 10d. Inside City Limits r 28a-f show 10e Stele 10h County 10c. City. Town or Location Maryland Baltimore Baltimore 1 ☐ Yes 2XXXIo Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with ir than "natural", or items 23s or 13 Chandelle Road 21220 U.S.A. Funeral 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) House Wife Own Home

permit. Pages 1 and 2 should be filed within 72 hours effer death 1 Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, it a Wed at Example 1000. Baltimore, Maryland 21215-0020

> **Physician** /Medical Examiner

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Division of Vital Records, P.O. Box 68760 Attending Physician: funerel n 24 hours effer on Funeral Director ŏ Hospital To the Hosp within 24 ho To the Fune completely fi

Registrar

31. Dete liled (Month, Day, Year) MAR 09

18 Mother's Name (First Middle Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Walter Gallus Wilhelmine Hilbert 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 1334 Broadway Road, Lutherville, Maryland 21093 Walter Radek (Son) 20e. Method ol Disposition 20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, Stete population 2 ☐ Cremetion 3 ☐ Removel from State Gardens Of Faith 3/10/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licanses 22. Name end Address of Fecility Bruzdzinski Funeral HOme, P.A. 23s /a/1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respireto thick, or heart leilure. List only one cause on each line. 1407 Old Eastern Avenue, Essex, Maryland 21221 (ardiac Immediate Cause (Final disease or condition resulting in deeth) Condianyopadhy Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting In deeth) Last Physician/Medical Due to (or es a consequence of): 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown py Completed 24e. Wes en eutopsy performed? 1 Tyes 20th Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XXIo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) sale D-38754 3-8-99 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) EASTERN BLUD, MD-21221 NASERM MAUKA

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32. Registrer's Signeture

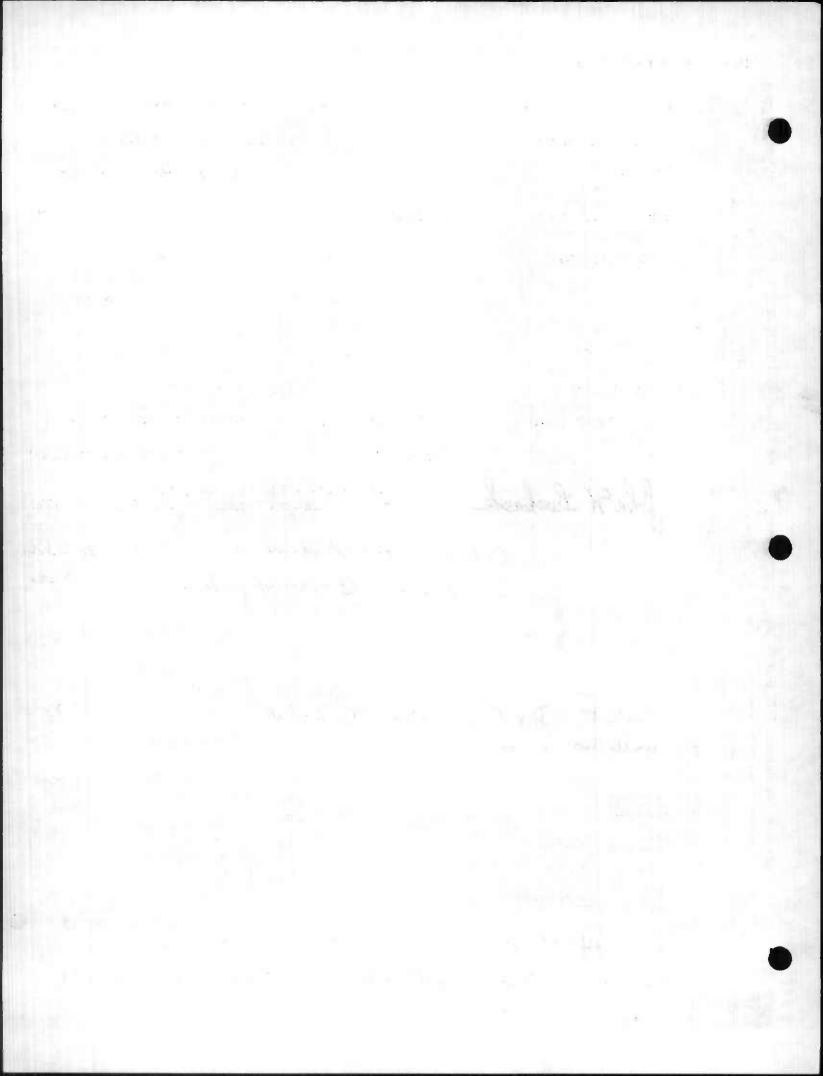
Approximate Intervel Between Onset and Deeth

24b. Were eutopsy findings eveilable prior to

completion of cause of death?

1 □ Yes 2 P No

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Item#17 perFHG769 3/9/99 EW Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death MARCH **Physician** 1999 1:20PM ELLA SCHERR /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER BALTIMORE If Under 24 Hrs If Under 1 Year 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys Months Hours 1□M 2□F MARYL AND 216-34-7788 87 Director Usuet Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Director MD BALTIMORE BALTIMORE 10a. Citizen of Whet Country? 10e. Street and Number 10f. Zio Code 8 POMONA NORTH APT 11 21208 U.S.A. death y Funeral Wes Decedent Ever in U,S. Armed Forces?

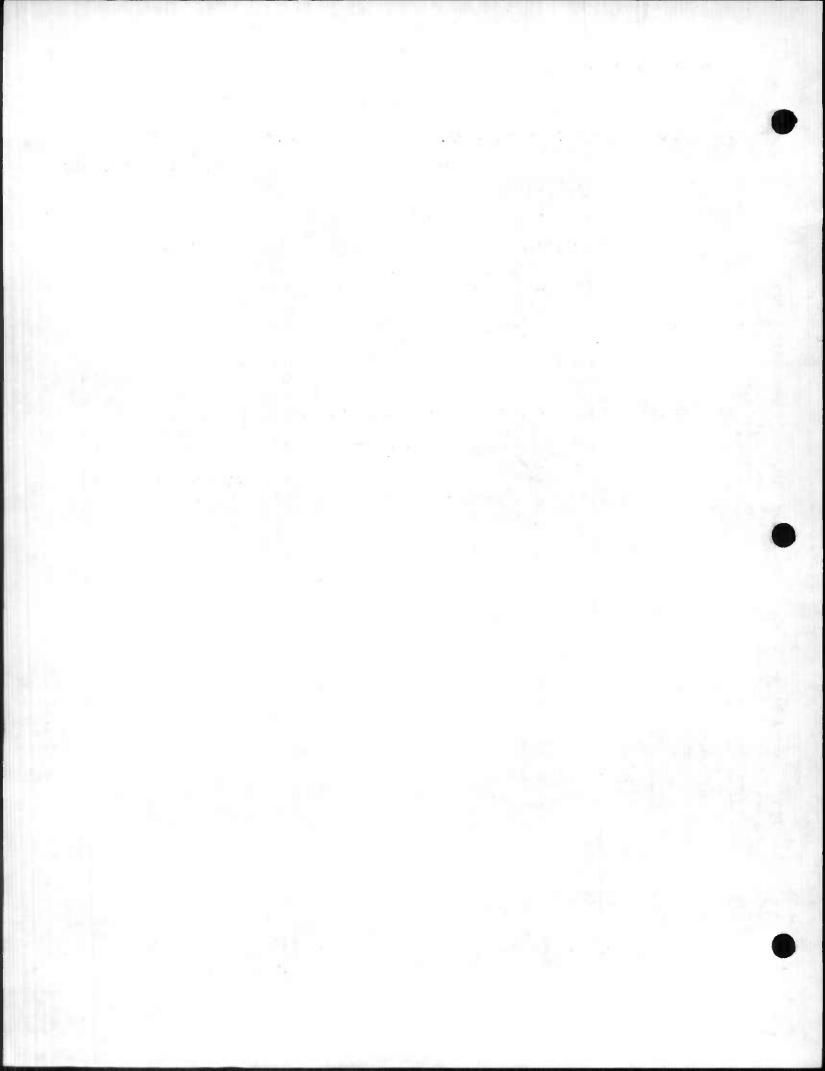
1 Yes XXNo
If Yes, Give
Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or their any Injury or other traumatic event, the Health is marked. 1 Nevar Married 2 Merned Specify WHITE 1 Yes ZNo altimore, Maryland 21215-0020 Specify: à 3€ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS SAUAL PAULA **ISRAELSON** Saval 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 POMONA NORTH APT. 11 BALTIMORE, MD 21208 MRS. MARIAN LONDON/ NIECE 20b. Piece of Disposition (Name of 20e. Method of Disposition
1 ⊠ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20c. Location - City or Town, State ANSHEVEMANUH ATTEO)CHAIM 3/4/99 BALTIMORE 5 Other (Specify) 4 Donatio CEMETERY CONG. 22. Name end Address of Fecility
SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Do not enter the moda of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Death **Physician** hehmania /Medical Immediata Cause (Finel diseese or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last hear P.O. Box 68760, The law requires that the death certificate be Physician/Medical Dua to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 KNo 3 Probably 4 Unknown JEDY OVOJIJ of Vital Records, by 24b. Were autopsy findings aveilable prior to Completed de mention 24a. Was en eutopsy performed? completion of cause of death? page 2 s mrls 2 No 1 ☐ Yes 2 ☐ No 25. Was casa refarred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No this funeral 27. Menner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? Atter Division 5 Pending investigation or Attending 1 Ki Natural n 24 hours after death.
he Funeral Director: Att
plately filled in by the fur 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, alreet, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical complately (Check only one) To the F within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier D 30339 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) Court Rd; Baltimon; Ms ola MA 4000 MILAN WISTER

DHMH 16 Rav 6/95

State Registrar 31. Data filed (Month, Dat. Mar)

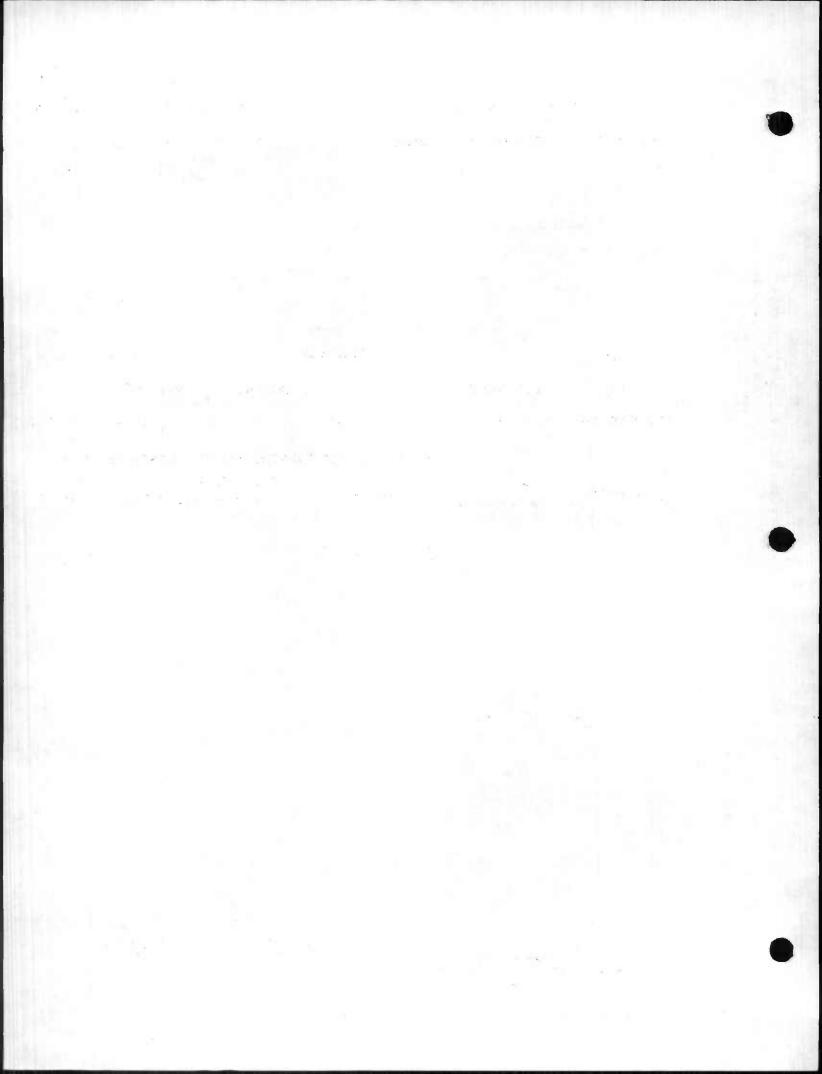
19932. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** SARA SHERBOW MARCH 1, 1999 5:45 AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRIGHTWOOD MERIDIAN NURSING CENTER LUTHERVILLE BALTIMORE If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 218-50-8587 95 9, 1903 Director APR. RUSSIA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Director 288-1 MD BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? b 515 BRIGHTFIELD ROAD 21093 Items 23a U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Reca - American Indian 11 Marital Status Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE à 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME Pages 1 and 2 should be filed v hent of Health and Mental Hygie int: If them 27 is marked other 1 17. Fether's Neme (First, Middle, Last) 16. Mothar's Name (First, Middle, Maiden Surname) Be NATHAN ROSENBLOOM (unknown) (unknown) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Department of Health is Important: If Item 27 is any injury or other tra THEODORE SHERBOW / SON 100 S. CHARLES ST. 15TH FLR. - BALTIMORE, MD 21201 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 3/7/99 REISTERSTOWN, MD 22. Neme and Address of Fecility SOL LEVINSON & BROS., INC. 21. Signature of Euneral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart tailure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Preumo N.t. immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physician a Box 68760. Physician/Medical Due to (or es a consequence of): 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by 1 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed 1 Tes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical axaminer? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Atter 5 Pending 1 Aleturel 1 Yes 2 No death. 2 Accident investigetion within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and menner stated. edical 29a. Certifier completely (Check only one) To the 29b. Signeture and the of carrier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 2/2/2 Schwartz mo 115 E. Mcfrase 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State Registrar MAR 9



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** FLORINE SCHNYDMAN MARCH /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) Examiner BALTIMORE JEWISH CONVALESCENT CENTER If Under 1 Year If Under 24 Hrs. 6. Date of Birth (Month, Pay, JUL 19, 7. Age (In yrs. last birthday) (State or Foreign **Funeral** 10 M 200 Yrs MD 86 Director 212-01-7360 Usual Residence of Decedent r 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 눕 Examiner must be r 21208 U.S.A. 8234 STREAMWOOD DRIVE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed The Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry then Elementery/Secondery (0-12) College (1-4or 5+) Hygiene ACCOUNTING DEPT. ACME FOOD 10 marked other permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If tem 27 is marked othe shy injury or other traumatic event page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be LANG ROSENBERG HORTENCE P SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8234 STREAMWOOD DRIVE - BALTIMORE, MD 21208 JERRY SCHNYDMAN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burlal 2 Cremation 3 Removal from Str 3/5/99 OWINGS MILLS, MD HAR SINAI CEMETERY 4 Donation 5 DOther (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 nat caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, one on each line. 23a. Part1! Enter the disease, shock, or heert failure. List b Interval Between Onset end Death **Physician** CEREBRAL HEMORRHAGE Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Examiner physicien and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of) 80 9SN ŏ signed by the a d be datached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No þ 24b. Were eutopsy lindings available prior to completion of cause of death? should s 24a. Was an autopsy performed? Completed is certificate hes director, page 2: 2000 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) 1□ Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Manne of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Wetural 2 No 1 ☐ Yes 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The lew requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, or Attending Physician: death. Director in 24 hou. Hospital edica To the Hospi within 24 hou To the Funer completely fil

the Maryland

with

filed within 72 hours after deeth

Registrar

29a. Certifier

(Check only one)

29b. Signal up and title of certifie

ValSHIM 32 Registrar's Signature 1999 MAR 9

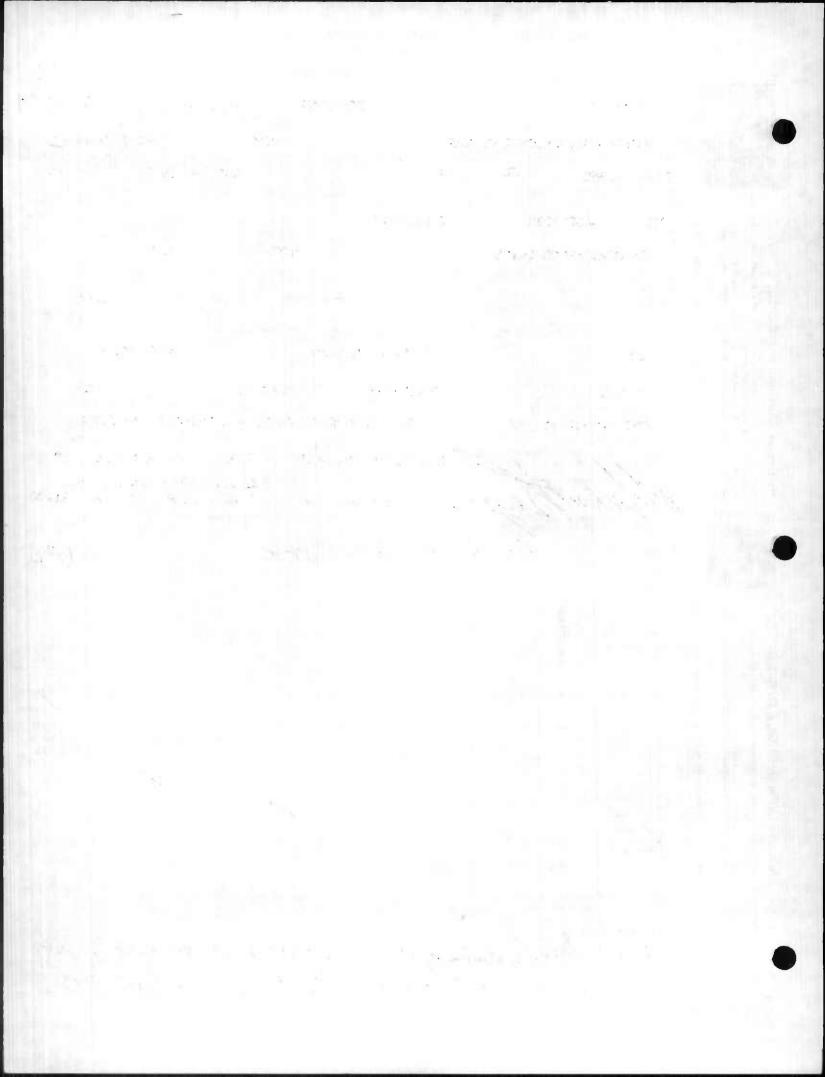
of person who completed cause of death (Item/23a) (Type, Print)

29c. License number

29d. Dete signed (Month, Dey, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, In my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician STEIN SAMUEL 8:50 AM MARCH /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) Examiner 40501m RANDALLSTOWN ORTHWES BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F 219-05-1336 JULY 4, 78 MD Director Usual Residence of Decedent the Manyland 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f ahow BALTIMORE 1 ☐ Yas Y No Director MD BALTIMORE 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7915 WINTERSET ROAD 21208 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. filed within 72 hours after Hygiene. ther than "natural", or its 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 WHITE 1 ☐ Yes 2 QNo Specify: Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: if Itam 27 ie marked other th eny Injury or other traumatic avent, the SALES PROMOTIONAL ITEMS 18 Mother's Name (First Middle Maiden Surgeme) 17. Father's Neme (First, Middle, Last) **ABRAHAM** STEIN IDA ABRAMOWITZ 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) LISA GROSSBART / NIECE 11095 HIDDEN TRAIL DRIVE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other placeSOCIETY) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) HEBREW ORTHODOX MEMORIAL 3/7/99 BALTIMORE, MD 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 21. Signature of Funarel Service Licenses Solvet 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Causa (Final MYOCARDIAL INPARCTION HOUR ACUTE disease or condition resulting in death) Examine Dua to (or as a consequence of) Examiner CORONARY YEARS DISEASE ANTERY physicien and the burial-transit the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or es a consequence of): YEARC MELLIN 68760 Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of): Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Onknown signed t Records. þ 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to Completed completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No of Vital Be 25. Wes case raferred to medicel examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient → DOA Certification: To this 27. Manner of Death 28a. Deta of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending 1 Diffeturel 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendiwithin 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide The Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of Cortifier 797587

State Registrar ROBERT

31. Date filed (Month, Dev. Year)

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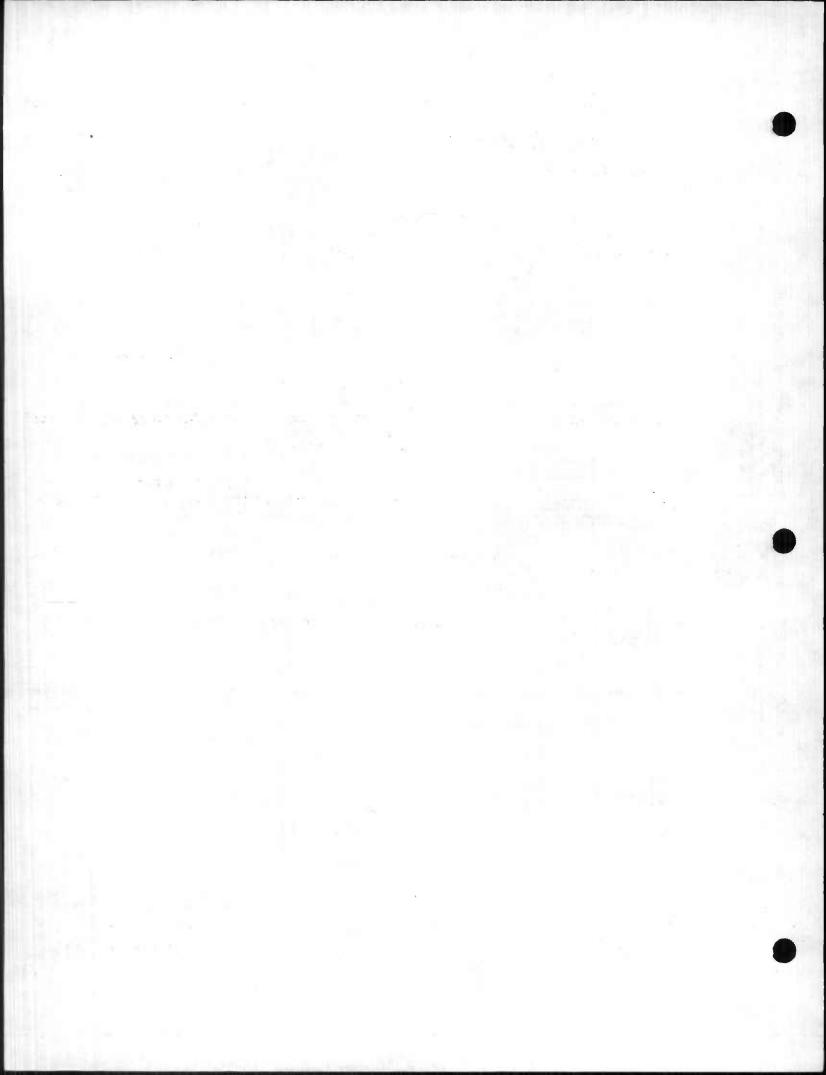
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

32. Registrar's Signature

2-1133

OLD COURT AD RANDAUSTONN UP



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 3. Time of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth Month ROBERT M. SILVER 10.15 1999 4b. City, Town, or Location of Deeth RANDALLSTOWN a Fecility Neme (If not institution, give street end number NORTHWEST HOSPITAL CENTER 4c. County of Death BALTTMORE If Undar 1 Yaar Months Days If Under 24 Hrs. 8. Deta of Birth (Month, 1971, Year) 17 7. Aga (In yrs. lest birthdey) 9. Birthpleca (Stete or Foreign 5 Sociel Security Number 6 Sex Days Min. Hours PENNSYLVANIA **XX**M 2□ F 81 Yrs. 217-03-3749 Usuel Residence of Decedent 10c City, Town or Location COCKEYSVILLE 10d. Inside City Limits 10e Stete 10b. County BALTÍMORE MD 14 Yas 2 No 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21030 5 RISES COURT 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Specify 1 ☐ Nevar Merried 2 ☐ Married No Yes 2 No 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Detas: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest greda completed) Elementery/Secondary (0-12) College (1-4or 5+) RETAIL OWNER 17 Fether's Nema (First Middle Lest) 18. Mother's Neme (First, Middle, Maiden Sumema) SPIRO BESSIE ELLIS SILVER 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 5 RISES COURT COCKEYSVILLE MD 21030 MRS. SYLVIA SILVER/WIFE 20b. Plece of Disposition (Neme of 20a. Method of Disposition

↑ Burial 2 □ Cremetion 3 □ Ramoval from State Dete 20c. Location - City or Town, Stete MTRO KODESH PETH ISRAEL 3/5/99 BALTIMORE MD 5 Other (Specify) 4 Donetion CEMETERY 22. Name and Address of Fecility SOL LEVINSON & BROS. INC. 21 Sign 8900 REISTERSTOWN ROAD PIKESVILLE, MD 1. Enter the disease, or complications, or heert failure. List only one care ications that causad the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, no cause on each line. Approximete Intervel Between Onset and Deeth Immediate Ceuse (Finel NEUMONIA I MONTH. disease or condition resulting in death) Due to (or es e consequence of) HEAR ONGES TIVE Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 Yee 2 No DEMENTIA 24b. Were eutopsy findings eveileble prior to 24e. Wes an autopsy completion of cause of death? 1 Tes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

ettending physician end for use as the buriel-transit lew requires that the death certificate be executed Box 68760 signed by the e Division of Vital Records, P.O. been si 300 pege 2 The certificate Attending Physician: director, this After thi death. efter death.

Director: A 9 the Funeral Di the Funeral Di npletely filled in

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f ahow bolical Examiner must be notified at

2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural, or her reumatic event, no Moulcal Experiments

permit. Peges 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 is marked oths any injury or other traumatic event, page.

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification:

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29a. Certifier (Check only one)

29b. Signatura and title of certifie

Baltimore, Maryland 21215-0020

Director

Funeral

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125, Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) end manner es steted.

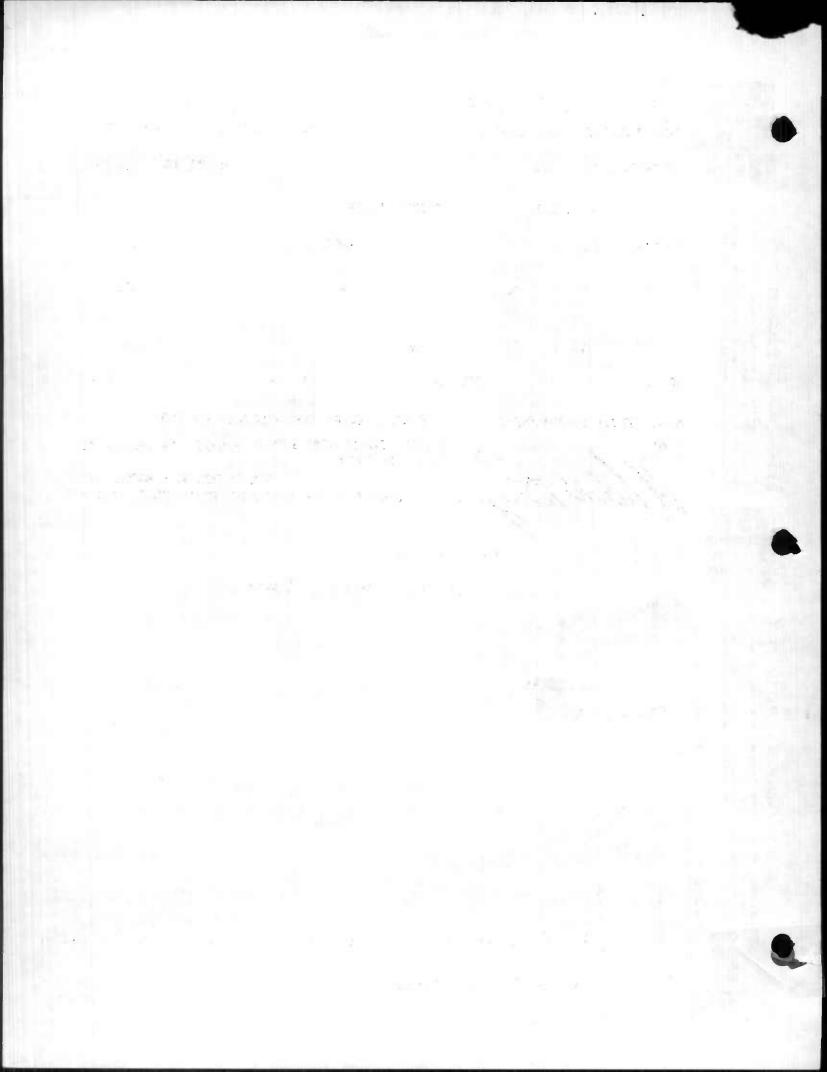
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end manner stated.

29d. Data signed (Month, Day, Year)

of person who completed cause of deeth (Item 23e) (Type, Print) 30. Neme end

RAMONUSTUUMN MO HUSPITAL Center LOGIMDER MENTA MUNTH WEST 31. Dete filad (Month, Day, Year) 32. Registrer's Signature 21133.

MAR 9



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death STEIN IETTY March 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death LEVINDALE NURSING HOME N/A BALTIMORE If Undar 24 Hrs. 5. Sociel Security Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foraign Country) Deys Months Hours 1 M 2 F Yrs. 216-56-5304 DEC. 18,1936 ROMAINIA Usual Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5715 PARK HEIGHTS AVE., APT.107 21215 U.S.A. 12. Was Decedent Evar in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Rece - American Indien. Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4X Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grede completed) JOHNS HOPKINS Elementery/Secondary (0-12) College (1-4or 5+) 4 LAB TECHNICIAN HOSPITAL 18 Mother's Neme (First Middle Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) MOSES **PFAU** ROSA TUCHMAN 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) MRS. RITA GROLLMAN/ DAUGHTER 722 GLADSTONE AVE., APT.2, BALTIMORE, MD 21210 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) BALTIMORE HEBREW CEMETERY 3/8/1999 BALTIMORE CITY, MD 22. Nama and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, 21208 23e. Pert1. Enter the disease, or complications at let ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear failure. List only one of a on each line. Approximate Interval Between Onset end Death Breast CANCER Immediate Cause (Final disaase or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents resulting in death) Lest Due to (or es a consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 2 No 1 ☐ Yes > No 1 ☐ Yes 25. Wes cese referred to medical examiner? 28. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 5 Pending investigation 1 Haturel
2 Accident 1 Yes 2 No

Physician /Medical **Examiner**

Department of Important: If it any injury or c

Physician

Examiner

Funeral

Director

"natural", or frems 23s or 28s-f show edical Examiner must be notified at

7 is marked other than "natur traumatic event, the Medical

Hygiene.

Pages 1 and 2 should be finent of Health and Mentel First: if item 27 is marked of

Director

Funeral

þ

Completed

Be

the Maryland

with

filed within 72 hours after death

Baltimore, Maryland 21215-0020

/Medical

attending physician and for use as the burial-transit as esn ed by the a page 2

certificate director, this funeral After 3

Examiner Physician/Medical

þ Completed Be To Certification:

Records. Division of Vital death. after i 6 To the Hospital 24 hours

completely within 2

State Registrar

edical

Certifying Phyeiclan: To the best of my knowledge, daath occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Certifying Phyeiclan: To the best of my knowledge, daath occurred et the time, dete end plece, end due to the ceuse(s) and menner stated. 29b. Signatura and fitta of certifier

3 Suicide

29e. Certifier

4 Homicide

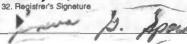
6 Could not be determined

29d. Deta signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

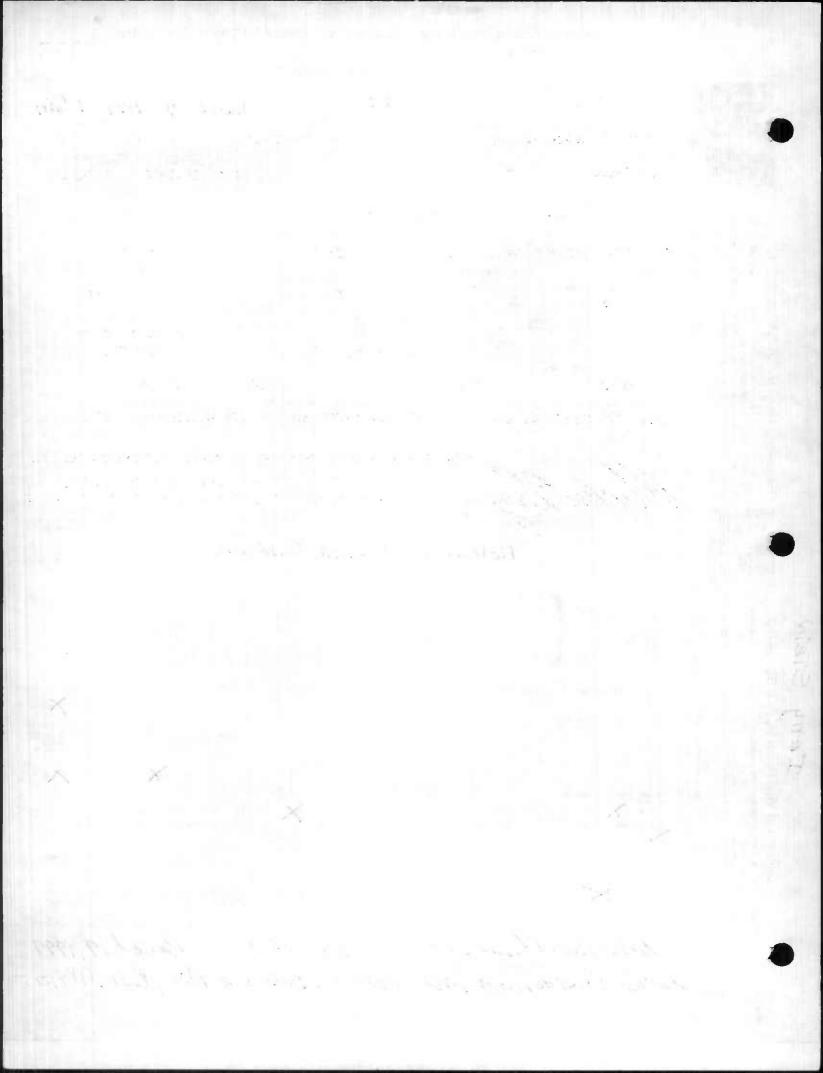
30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

W. Belleder Ave, Balto. Pd 21215 ND WERTHEINER 31. Deta filed (Month, Day, Year)

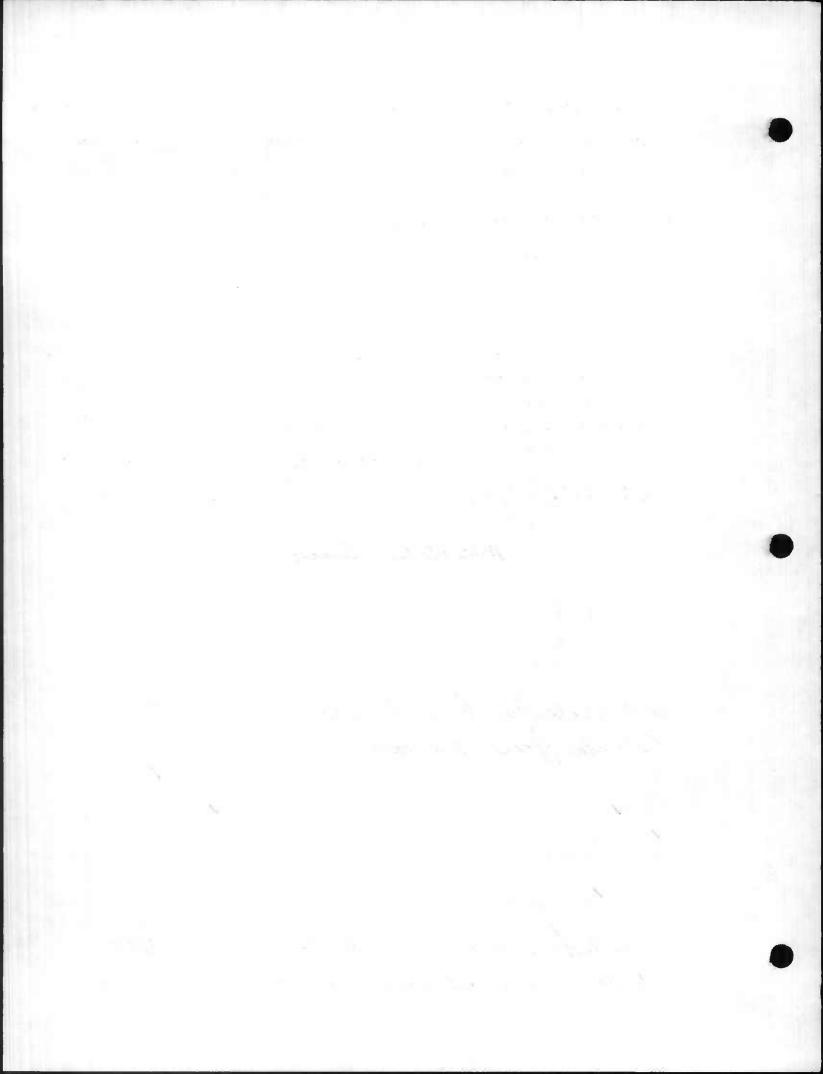


28e. Place of Injury - At home, ferm, streat, fectory, office building, etc. (Specify)

DHMH 16 Rev 6/95



			Certificat	te of Death	Re	g. No.	
	1. Decedent's Name (First, Middle, La	st)			2. Date of Deeth Month	Dey Year	3. Time of Deeth
Physician /Medical	Cristina	P. Schi	meiser		MARCH	6, 1999	
Examiner	4a Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death	4c. County of De	ath
<u> </u>	918 Marine D	rive		Annap	olis		rundel
Funeral Director	045 - 28 - 4150	ex 7. Age (In yrs. 73	Yrs. If Unde Months				irthplece (State or Foreign Country) erto Rico
ehow of any of a	Usual Residence of Decedent 10a. State 10b. County		y, Town or Location			4	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the Maryle 128a-f eho	MD Anne A	rundel	Annapolis	o Code	1/	og. Citizen of Whet (
ifter deeth with the Mai r items 23s or 28s+f e in real man be northed Funeral Director	918 Marine Dr	ive	101. 21	21401		USA	2001 My F
by Lin	11. Marital Stetus 1 Never Merried 2 Married 3 V Widowed 4 Divorcad	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Yeer or Dates:		2 No Specify:	Specify Yes or No- nto Rican, etc.) 1erto Lean	Black, Wh	nerican Indian, hite, etc. White
natural,	15. Decedent's Ed (Specify only highest gra	ducation	16a. Decedent's Usu (Give kind of wo	al Occupetion	orkina	16b. Kind of Busines	s/Industry
ithin an in	Etementery/Secondery (0-12)	College (1-4or 5+)		ork done during most of wo use retired)			
pemit. Peges 1 and 2 should be filed within 72 hou Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "nature ny injury or other traumatic event, the Medical Date. To Be Completed	17. Father's Name (First, Middle, Last,	ra Leal	Executive	18. Mother's Ne	eme (First, Middle, M	Banking Maiden Surmame) e Hinche	
Men Men Men Men Men Men Men Men Men Men							
2 sh and is m	19e. Informant's Name/Relationship (s (Street and Number or F			
l and lealth m 27 her t	Rhonda DeWindt/dau	ighter		ne Drive	Annapol	1S, MD 20c. Location - City of	21401
emit. Peges 1 ar Pepartment of Hea mportant: if Itam 2 ny Injury or other INCE.	20a. Method of Disposition 1 Buriei 2 Cremation 3 C 4 Donation 5 Other (Specif	Hemoval from State	Place of Disposition (Na cemetery, crematory or tro Cremato	other place) ory, Inc. 0			
permit. Peg Department Important: I any Injury o	21. Signature of Funeral Service Licar	c D male	Crema	nd Address of Fecility tion Socie rederick F			
100 100	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plicetions that caused the deat	h. Do not enter the mo	de of dying, such as cerdia	ac or respiratory arre	est,	Approximate Interval Between
Physician		one cause on each line.					Onset and Deeth
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	· melas	ales C	ance			
	resulting in dealty	Due to (c	or es a consequence of)	:			
ecuted and transit	Sequentially list conditions,	b. Due to (c	or as e consequence of)	:			t
intificate be executed ing physician end a set the buriel-transit	if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last	cDue to (o	or as a consequenca of):		-		
attending I for use e		d			1		
net the d d by the deteched	Pert II. Other significant conditions of	ontributing to death but not res	The Little of the underlying of the Little o	cause given in Part I.			re to the cause of death Probably 4 Unknown
been should	Volvular /	Frant De	rease		24a. Was er perform	n eutopsy 24t ned?	b. Were autopsy findings available prior to completion of cause of death?
e hes age 2					1□ Ye	s 2 No	1 ☐ Yes 2 ☐ No
certificate rector, pag	25. Wes case referred to medical			26. Place of Di	eath (Check only on		
sicia sirect direct	examiner?	Hospitel: 1 Inpatient 2	ER/Outpatient 3□ D	Othor			necify)
ding Physith. After this stunerel di	1 Yes 2 No						
or Attending letter death. Director: After din by the fune	3 Suicide 6 Could not b 4 Homicide determined	9 One Disea of January Albama form street feeton; effice 29f Location (Street and Number or Bural Boute Num					Rural Route Number,
To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com		ysician: To the best of my kno niner: On the basis of examina and manner stated.					
Mee Mee	29b. Signature and title of certifier	and manifer stated.	29	c. License number	2	9d. Date signed (Mo	onth, Day, Year)
F 3 F 8	1 1-1	- 41 1				2/7/	
	- ununga	ue NI.9		53386		7//2	/
	30. Name and address of person who Curfis Harris N	1. D. 600 Ridge	LY AVE ST	123/ Ann	apolis pr	11 214	0/
State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Signa	Hure B. Spa	els!			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth Month **Physician** 1999 MARCH 2:15PM /Medical Jack Leon Snyder 4e. Fecility Neme (If not institution, give street end number 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Dey, Year) 3-19-1924 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours **№** 2□ F 219-14-8737 Director 74 Maryland Usuel Residence of Decedant 10a Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Timonium 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 3 Baratra Court Unit 102 21093 U. S. A. Funeral Hems 12. Was Decedent Ever In U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merltei Status 1 ☐ Yes 2 ☑XNo If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 Married "natural", or 1 Yes 2 No Specify: λq Specify: White 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Reconsideration Examiner Social Security 12 pemit. Pages 1 and 2 should be filed Deperment of Heelth and Mental Hygiv Important: if item 27 is marked other 1 any Injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Surname) Be Roy Samuel Snyder Catherine Cramer Butts 10 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Mrs Audrey C. Snyder (Wife) 3 Baratra Court, Unit 102, Timonium, Maryland21093 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Moreland Memorial Park 3-7-99 Parkville, Maryland 22. Name end Address of Fecility
Ruck Towson Funeral Home, Inc. 21. Signeture of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failura. List only one ceuse on each lina. 1050 York Road, Towson, Maryland 21204 Approximete Intarval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examine buriel-trensi Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Diseese or Injury that initieted events resulting in daeth) Lest pue physician a the buriel Physician/Medical Due to for an a consequence of) attending p Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed hes page 1 TYes 255 No 1 ☐ Yes 2 XNo certificete 25. Wes cese referred to medice Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 8 Other (Specify) 10 1 Yas 2 No 1 MInpatient 2 ☐ ER/Outpatiant 3 ☐ DOA this 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred After 1 Natural 5 Pending efter death. investigation 1 Yes 2 No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital owithin 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowladga, daath occurred et the time, data and place, and dua to tha cause(s) end menner es steted.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha time, data and place, end dua to the cause(s) end menner stated. 29e. Certifiar Medicai 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ress of person who complated causa of death (Item 23e) (Type, Print)

And Torrio Lt. M.D., 740/05 2401 Osbor Drive Soute 201 Trason, D 31. Date file (Month, Day, Year) 32 Registrer's Signeture State MAR 0 9 1999 Registrar

DHMH 16 Rev 6/95

Hygiene.

Baltimore.

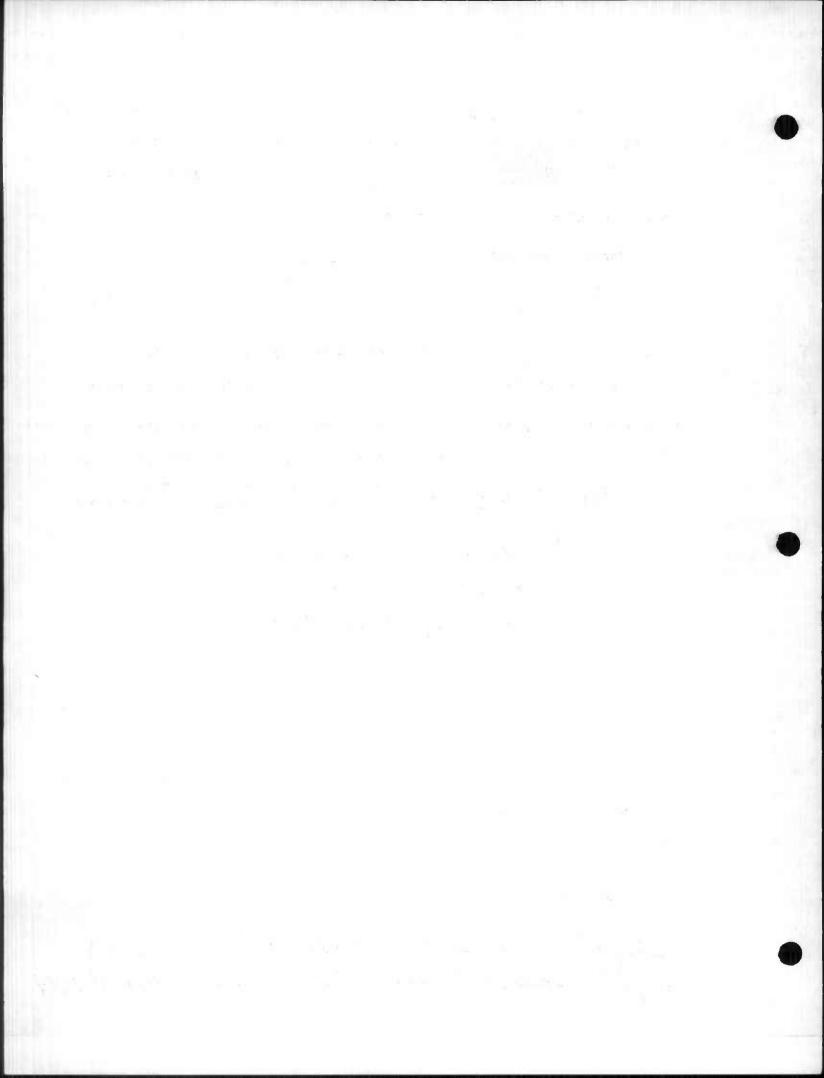
Box 68760

P.O.

Records,

Division of Vital

Hospital or Attending



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH Physician VIRGINIA SAPPINGTON 4:42 P.M. MARIE 1999 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Glen Burnie Anne If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) AUGUST 4 1921 Mariner Health of Glen Burnie Anne Arundel If Under 1 Yeer Birthplace (State or Foreign Country) Mary land 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□M 2♥F Months 214-05-2140 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Glen Burnie 10e Street and Number 10f. Zin Code 10g, Citizen of What Country? 1418 Gordon Drive 14. Rece - American Indian, 21061 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Merried WHITE 1 ☐ Yes 2 🖺 No Specify. Specify 20 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Household 8th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Samuel Better Martha E. Phelps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1418 Gordon Drive Glen Burnie MD 21061 Date | 20c. Location - City or Town, State James Sappington spouse 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cemetery 3/5/99 Crownsville MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee STALLINGS FUNERAL HOME P.A. 3111 Mountain Road Pasadena, MD 21122 23a. Pert1. Enter the disease, of complications that caused the double shock, or heart feilure. List only one cause on each tine. Approximate Intervat Between Onset and Deeth Do not enter the mode of dying, such as cardiec or respiratory arrest, Immediate Cause (Final Cerobrovascular Acriden disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 □ No investigation 2 Accident

attending physician and for use as the burial-transit certificata be axecuted Box 68760. Division of Vital Records, P.O. signed by t peed : has certificate after death.

Director: After this certific To the Hospital of within 24 hours a To the Funeral D

Funeral

Director

mast be notified at

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health end Mental Hygiena.

Important: If item 27 is marked other than "natural", or ther any injury or other traumatic avent, the Medical Franch PAGE.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

edical

DHMH 16 Rev 6/95

State Registrar

USHA SRIHARI 31. Dete filed (Month, Dey, Year)

29b. Signature end title of certifier

3 ☐ Suicide

29a. Certifie

4 Homicide

(Check only one)

MAR 9 1999

6 ☐ Could not be

32. Registrer's Signature

Suttai MEDICINE

NTERNAL

28e. Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
USHA SRIHARI VEMULAKONDA SI SUITE 208

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29c. License number

051104 1600, CRAIN

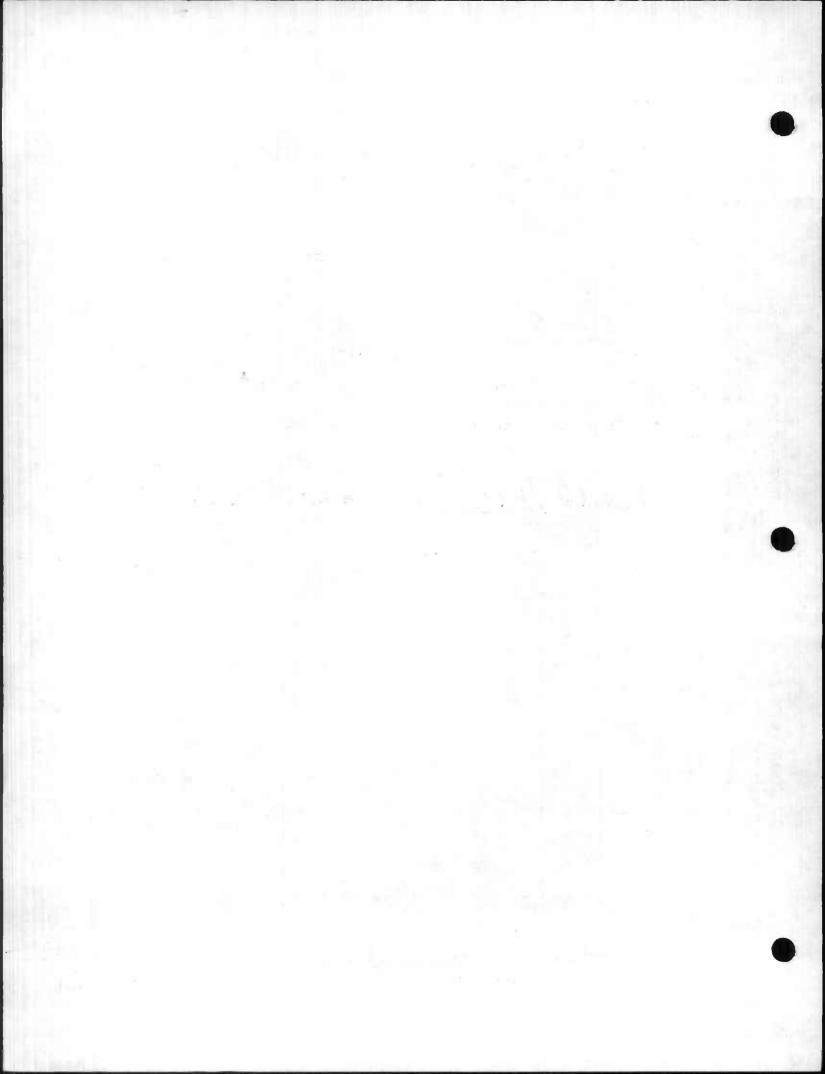
28f. Location (Street and Number or Rural Route Number, City or Town, State)

HIGHWAY

GLEN BURNIE

29d. Date signed (Month, Day, Year)

21061



Please Type or Print in Black Indelible Ink Assure All Copies Are Legible

ype of Fillt in black indelible lik. Assure All Copie	es vie redinie	0
State of Maryland / Department of Health and Mental F	Hygiene 9 0 14 1	2
PRA-E PER MED 6760 Confificate of Death		

•	
Physician	
/Medical	
Examiner	

ITEMS: #1, 23 PART I, 27, 28A-F PER MEO G769 1. Decedant's Name (First, Middle, Last)

Ε.

2. Date of Death 3. Time of Death FEBRUARY 25, 1999 09:50 AM

John 4a Facility Name (If not institution, giva street and number)

Sipes 4b. City, Town, or Location of Death BALTIMORE

4c. County of Death

N/A

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "naturel; or ite any Injury or other traumatic avent, I'm Madical Experies

Physician /Medical

Examiner

sician and bunal-transit

physician

the

SES esn Po

signed by the a d be detached t

has page 2

certificata

After this

after death. Director: Aft

24 hours a

To the To the To the

funeral director,

filled in by

Hospital or Attending Physician:

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020

215-82-4794 Usuai Residence of Decedent 10a Stete the Maryle item 27 is marked other than "naturel", or items 23s or 28s-f aho other traumatic avent, the Medical Examinar must be notified at Maryland Directo

Funeral P Completed Be

2

Examiner

Physician/Medicai

by

Completed

Be

Certification: To

edicai

1305 EAST PATAPSACO AVENUE 5. Social Security Number 1 M 2 □ F

7. Age (In yrs. lest birthdey) Yrs. 36

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Dey, Year) | April 19, 1962

 Birthpiece (Steta or Foraign
Country) Maryland

N/A

Baltimore

10c. City. Town or Location

10d. Inside City Limits 1 X Yes 2 □ No

10e. Street and Number

1305 East Patapsco Ave. 11. Maritai Status

10b. County

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Give Yaar or Dates:

 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yes 2 No Specify:

21225

14. Race - American Indian, Black, White, etc. Specify: White

1 Navar Marriad 2 Married 3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

10g. Citizen of What Country?

USA

Elementery/Secondary (0-12) 12

on each line

Sheet Rock/ Dry Wall

10f. Zip Code

Construction

17. Father's Name (First, Middle, Last) Raymond

Sipes

Mary

18. Mother's Neme (First, Middle, Meiden Sumeme) Damico

19a. tnformant's Name/Relationship (Type, Print)

Mary Sipes (Mother) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

402 Quit Woods Ct. Pasadena, Md. 21122 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca)

20c. Location - City or Town, State

20a. Method of Disposition

1 ☐ Burial 2X Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Metro Crematory Inc.

2/27/99 Baltimore, Md.

22. Name and Address of Facility
Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest,

immediate Cause (Final disease or condition resulting in death)

NARCOTIC INTOXICATION

Dua to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Due to (or as a consequenca of)

Due to (or as a consequence of):

23Ь.	Did	tobacco	uaa	contri	buts	to the	CSUSO	of death?
	1 🗆	Yes #	PN	0 3	□ Pr	obably	4	Unknow

24a. Was en autopsy performed?

24b. Ware autopsy findings available prior to completion of cause of death?

Approximate Interval Betwaen Onset and Death

18 Yes 2 No 1 ☐ Yes 2 ☐ No

25. Was casa referred to medical exeminer?
1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) Found: 2-25-99 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found: RESIDENCE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28b. Time of Found: 9:45

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 🖾 No

28d. Describe how injury occurred UNKNOWN

281. Location (Street end Number or Rural Route Number, City or Town, Stete) 1305 E. PATAPSCO AVE.

26. Place of Death (Check only one)

BALTIMORE, MARYLAND

29a. Certifier

1 Naturai

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piaca, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signatura and title of certifies lime

OCME

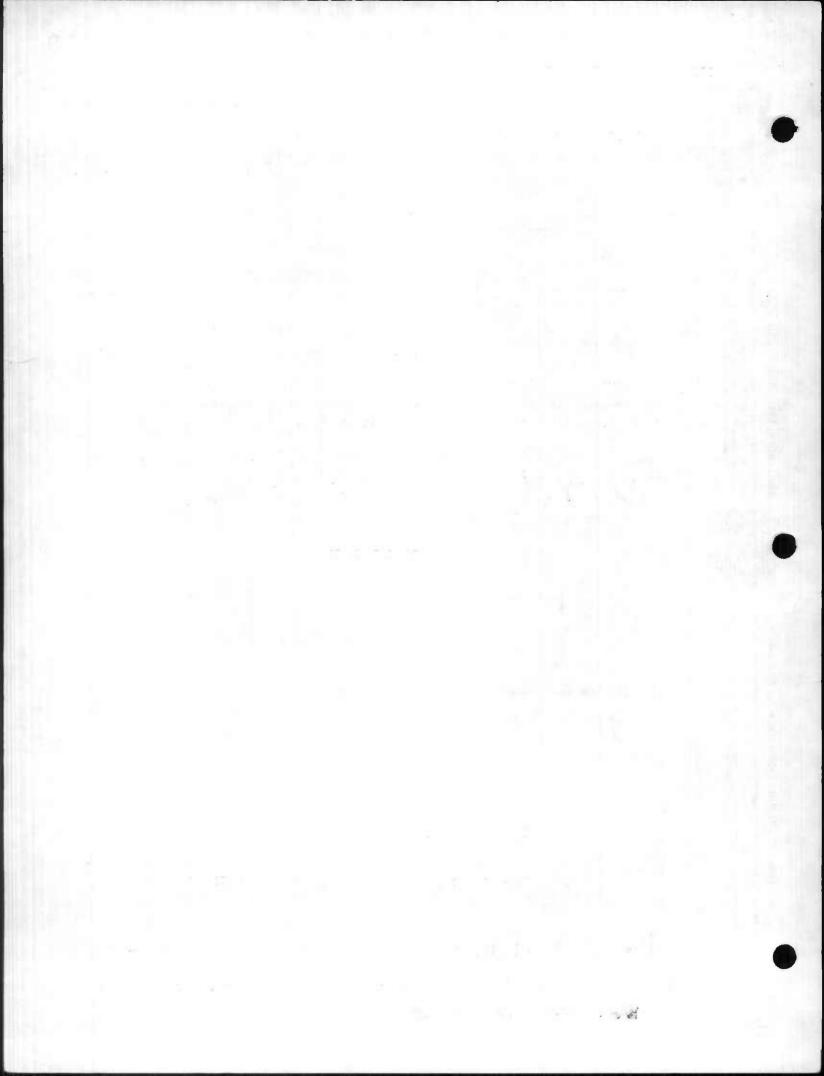
FEBRUARY 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1saysains D. KORTU MA

111 Penn Street, Baltimore, Maryland 21201

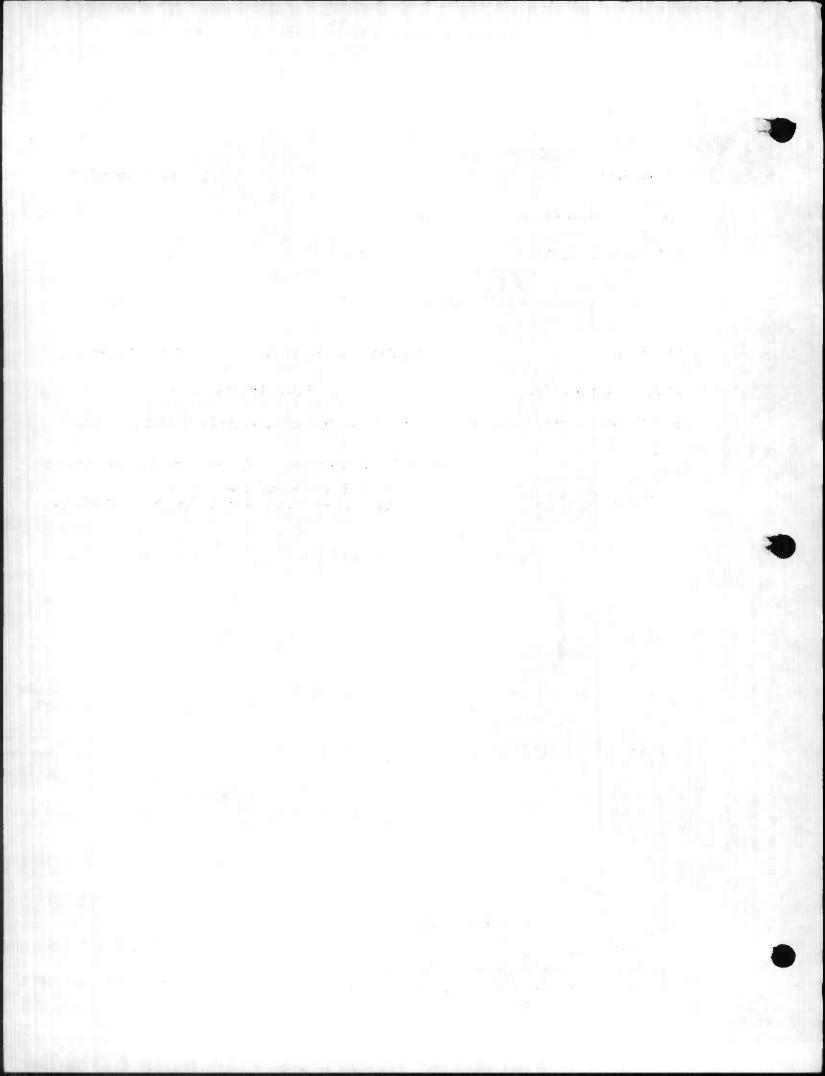
State Registrar 31. Date lied (Month, Dey, Yeer) 1999 32 Registrar's Signature



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State of Maryland / Department of Health and Mental Hygieneg 9 07480

			(Certificate of	Death		Reg. No.	0/400		
Share to the	1. Decedent's Name (First, Middle, L.					2. Date of D		3. Time of Death		
Physician /Medical	Kobert	S,	Str	ider		Marc	h 5	1999 12:10 AM		
Examiner	4a Facility Nama (If not institution, gi	- 1		. 1		or Location of Dea				
		gional	Hospita			urel		ce George's		
Funeral Director		Sex 7. A 1₩ 2□ F 6	ga (In yrs. last birth	Months Day		Irs. 8. Date of Bi (Month, D Mar 2.		Birthplace (State or Foreign Country) Maryland		
yend /lend	10a. Stata 10b. County		10c. City, Town	or Location				10d. Insida City Limits		
the Merylen 28a-f ahow notified at	MD Anne A	rundel	Laurel					1 ☐ Yes 2 💢 No		
firer death with the Me ritems 23s or 28s4 s firer must be motified funeral Director	10e. Street and Number 241 Marganza South 10f. Zip Code 20724 USA							hat Country?		
Dy by	11. Marital Status 1 □ Never Married 2 ↑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Armed Forces 1 X Yas 2 ☐ If Yes, Give Year or Dates:	?	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 💆 No		(Specify Yas or N erto Rican, etc.)	C//	e - Amarican Indian, k, White, etc. White		
Z = Z	15. Decedent's E (Specify only highast gi Elementary/Secondery (0-12) Grade 11		5+)		adent's Usual Occupation va kind of work done during most of workin DO NOT use retired) CTRONICS Engineer		16b. Kind of Bu			
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S saby W	Robert Hugh Strie					Louise W				
arylar 2 should be end Menta end Menta end merked ourmetic or	19a. Informant's Name/Relationship		19b. I	Walling Address (Stre				State, Zip Code)		
end 2 seath or 127 is	Pearl Irene Stri			11 Marganz						
or Health item 27 i other tre	20a. Method of Disposition			Disposition (Name of crematory or other p		Date	-	City or Town, State		
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Baltim permit. Per Departmen Important: eny injury once.	21. Signature of Funeral Service Liga		Loudon	Park Ceme		3/0/99	Daltillo	re, Maryland		
Ball permi	Donaldson Funeral Home, P.A.									
-	23a, Part1, Enter the dissurer or cor	nplications that cause	d the death. Do no	313 Talb	ott Ave.	Laurel,	Maryland	20707–4389 Approximate Interval Between		
.Physician	Onse									
/Medicai	Immediate Cause (Final disease or condition Acure Myocordial Infarction the									
Examiner	resulting in death)	a	Due to (or as a co					1 1000		
je je			500 10 (5. 00 0 0)				
68760, rificate be executed to physician and es the burial-transit Addical Examiner	Sequentially list conditions,	b	Dua to (or as a co	ensaquance of):						
Ex Line I	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avants									
68760, ficate be ex physician s the buria	Cause (Disease or injury that initiated avants resulting in death) Last C. Due to (or as a consequence of):									
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Geath cert death cert e attendin of for use		d								
he deed the all	Part II. Other significent conditions	the underlying cause	ng cause given in Part I. 23b. Did tobacco use contribute			tribute to the cause of death?				
P.O. het the de ad by the a deteched	Hypertansia Ancuma					1 Yes 2 No 3 Probably 4 Tonknow				
ords, P.O requires that the een signed by th hould be deteche						24a. Was an autopsy 24b. Were autop				
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The la						1	Yas 2 No	1 ☐ Yas 2 ☐ No		
Of VItal Physician: The this certificate ral director, page 1: To Be Co	25. Was case referred to-medical examiner?	Hospital:				Death (Check only	one)			
T sign	1 Yes 2 No		ient 2 ER/Out	Balleril 3L DOA			sidence 6 Othe			
After fune	1 Netural 5 Pending	28a. Date of Inj (Month, D	ury ay Year) 28b. Ti		jury at /ork? □ Yas 2 □ No					
Attended death closes by the	2 Accident investigation M 1 3 Sulcide 6 Could not be determined Celement Sulcide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, officially sulcided to the determined sulciding, etc. (Specify)									
Div. To the Hospital or / within 24 hours after To the Funeral Dire completely filled in the Medical Certi	29a. Certifier 1 ☐ Certifying P (Check ∂phy one)	(Check only 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
Ne the	29b. Signature and title of certifier	011		29c. Lica	nsa number		29d. Data signed	Month, Day, Year)		
-,-,	1 / lillamor	1 te	1000	0	2967	11	3/	17/99		
, \ \ \	30. Name and address of person who	completed cause of	deeth (Item 23a) (T	ype, Print)	, , ,		0/	of the		
10	VillAMOR	S. REY	EX M	D. 65	01 Lan	dover	RU'e	haral ort		
State	31. Date filed (Month, Day, Year)	1000 32. Regist	rans Signature	1	-			1)		
	MAR 9	555	The state of the s	17 1	20.11					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** · U AM 4b. City, Town, or Location of Death 4c. County of Death Charles Frank Schwarz /Medical 4a Facility Name (If not Institution, give street end number) Examiner Fallston General Hospital Fallston Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2□ F Yrs. 705-09-8759 **Director** Feb. 24, 1917 Baltimore Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland | Baltimore Examiner must be notified Baldwin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 10 Palm Way Court 21013 12. Wes Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No APMY If Yès, Give Yeer or Detes: 1941/45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced "natural", White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Aberdeen Elementary/Secondary (0-12) College (1-4or 5+) Proving Grounds 12 yrs. 2 yrs. Automotive Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mental merked Charles J. Schwarz Dorothy Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Health tem 27 I Mrs. Adele H. Schwarz (Wife) 10 Palm Way Court Baldwin, Maryland 21013 altimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ♥ Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem.Grds. 3/2/99 | Towson, Maryland 22. Name and Address of Facility E.F.Lassahn Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 11750 Belair Road Kingsville, Maryland 21087 Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medicai CHRONIC RENAL FAILURE OHE MOUTH Examiner ACUTE TUBULAR NECROSIS AND EMERGENCY

Due to (or as a consequence of):

1 SET A IEDUN BOTTOM Physician/Medical Examiner DUE MORTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LEFT NEPHRECTOMY HEMORIKAGIC SHOCK ONE MINTH RUPTURE OF THE LEFT RENAL ARTERY DIE MONTH Part II. Other significant conditions 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown METABOLIC AND HYPOXIC ENþ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy CEPHALOPATHY 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA examiner?

1 Yes 2 No

27. Manner of Deeth

1 Natural

2 Accident Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 2 🗆 No 1 ☐ Yes 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral Di the certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edicai within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year)

HOSPITAL 100 MUTON AVENUE FALLSTON, MARYLAND 21049

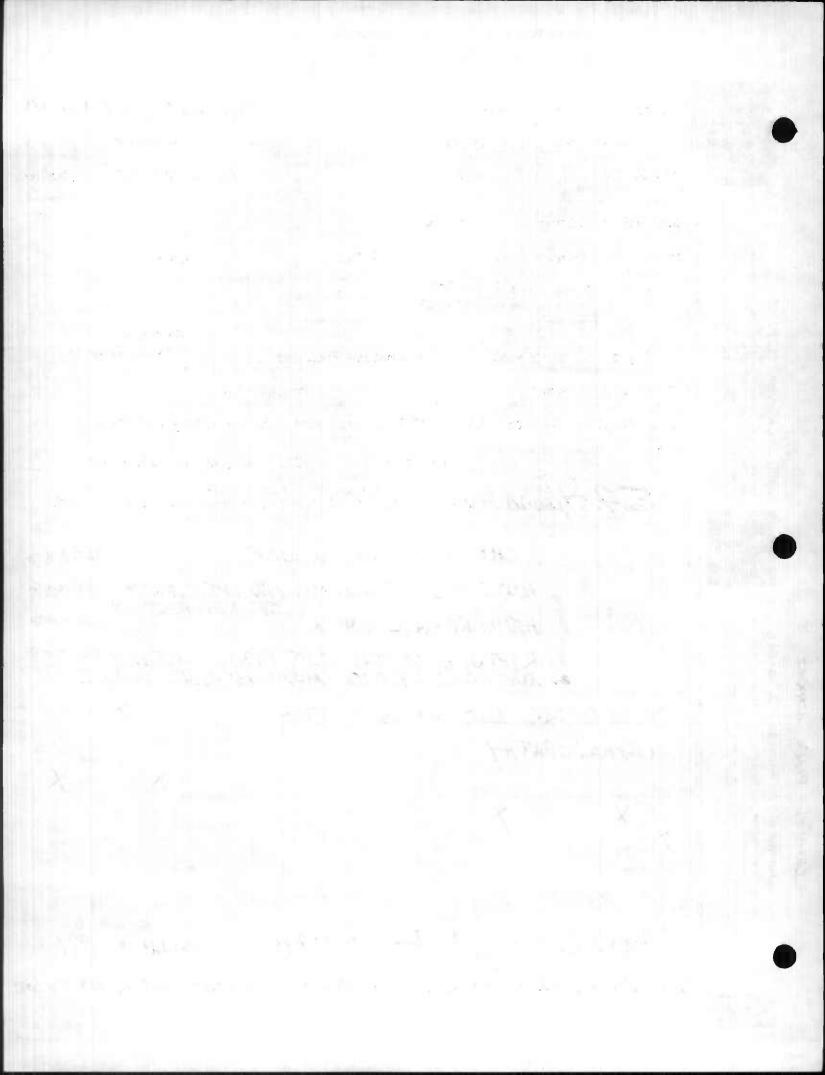
Registrar

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Yeer)

32. Registrar's Signature

MAR 9



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death Month 3. Time of Death Year Bohdan Shepelavey March 5, 1999 5:50PM 4a Facility Nama (If not institution, give street and number) 10135 Spring Pools Lane 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) June 24, 1929 If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 M 2 □ F Ukraine 102-26-2536 Usual Rasidence of Decedant 10c. City, Town or Location 10a. Stata 10d. Inside City Limits Howard MD Columbia 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10135 Spring Pools Lane 21044 USA Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ঐ No If Yas, Giva Yeer or Detes: 1 ☐ Navar Marriad 2 ☐ Married Specify: White 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry 5+ College (1-4or 5+) Elementary/Secondary (0-12) Physicist Radar Analyst 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Father's Nema (First, Middle, Last) Stepan Shepelavey Kateryna Vynnyk 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Christina Shepelavey Wife 10135 Spring Pools Lane, Columbia, MD 21044 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 □ Cremetion 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 3/9/99 Clarksville, MD Columbia Memorial Park 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funaral Sarvice License 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final Respondent Failure disaasa or condition rasulting in death) Dua to (or as a consequence of): Gastric Admocarisama Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown anemia, Anorexia-Calhexia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical **Examiner**

physician and s the burial-transit

signed by d

al or Attending Physician: T s after death. Il Director: After this certifical ed in by the funeral director, p

To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by

P.O. Box 68760,

Records.

Division of Vital |

Examiner

Physician/Medical

à

Completed

Be

Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-1 show odical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
important: If them 27 is methed often

altimore, Maryland 21215-0020

Director

Funeral

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Sequantially list conditions, if any, laading to immediate causa. Entar Undartying Cause (Disaase or injury that initieted evants rasulting in daath) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Throm bocy topenia

1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ona)

25. Was casa rafarred to medical examiner? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accident 6 ☐ Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

29a. Cartifiar 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. (Check only one) 2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar

CM

29c. License number 29d. Data signed (Month, Day, Year) 030543 3-6-99

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

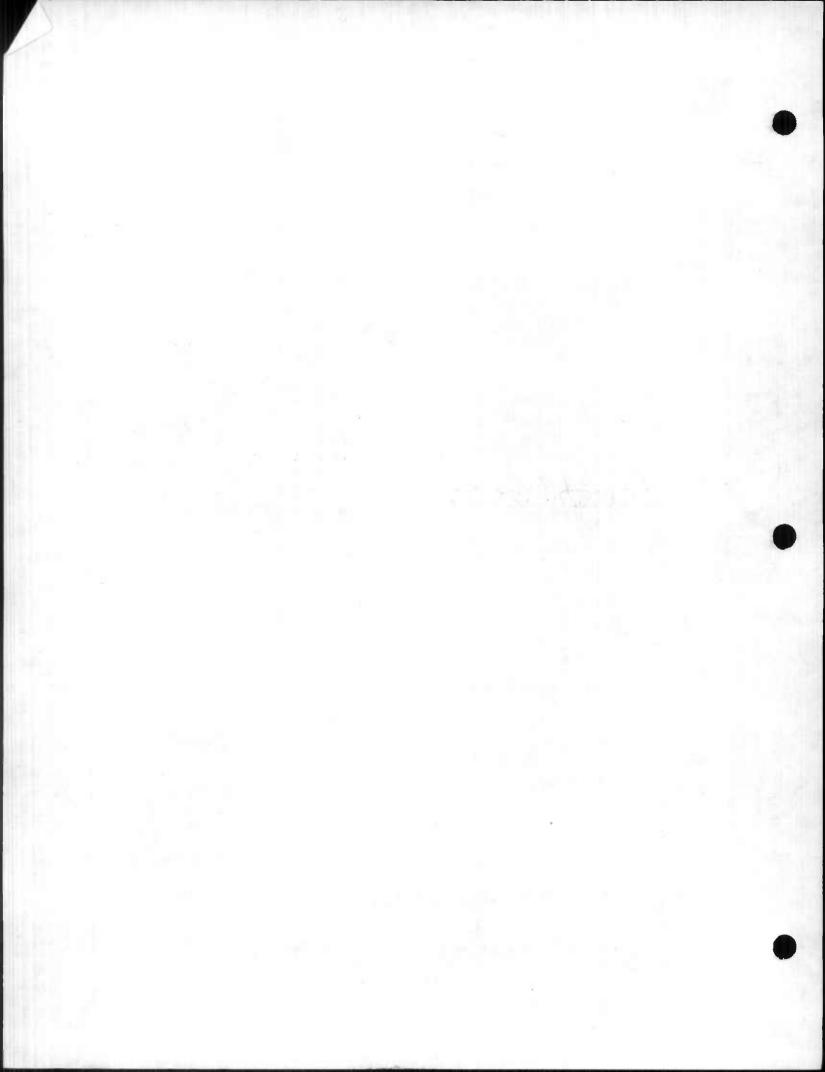
Butrik MA 2 Know Neath Columbia MY 27045 31. Data filed (Month, Day, Year)

Registrar

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32. Registrer's Signatura - neel



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death 2. Data of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Dav **Physician** March 5, 1999 11:44 AM Edna V. Sauerwald /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner 108 N. Essex Avenue Baltimore Essex If Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign
Country) **Funeral** Months 1□ M 2□ F Yrs. 84 Oct. 13, 1914 Baltimore Director 220 36 0276 Usuai Rasidanca of Dacedant with the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow 1 ☐ Yas 2 ☐ No Directo Maryland Baltimore Essex 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? r than "natural", or Items 23s or the Medical Examiner must be a 108 N. Essex Avenue 21221 USA death Funerai 12. Was Decedant Ever in U,S. Armad Forcas? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indian 11 Marital Status Black, White, atc. permit. Pages 1 end 2 should be filed within 72 hours after Department of Health end Mental Hygiene. Important: If Item 27 Ia merked other than "natural", or ite 1 ☐ Nevar Marriad 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: à 3 ₩ Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16h. Kind of Business/Industry Elementery/Secondary (0-12) Coliaga (1-4or 5+) Housewife Own Home raumatic event, i 18. Mothar's Nama (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middla, Last) (unknown) King Frances (unknown) 19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Raiationship (Type, Print) 8818 Avondale Road Baltimore, Maryland 21234 Robert P. Sauerwald (son) Item 2. 20b. Place of Disposition (Nama of cemetery, cramatory or othar place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1

Burial 2 □ Cremetion 3 □ Removei from Stata

□ Donation 5 □ Othar (Specify) Important: If It any injury or c Parkwood Cemetery March 8,1999 Balto County Maryland atura of Funeral Service Licensee 22. Nama and Address of Facility
Bruzdzinski Funeral Home PA 1407 Old eastern Avenue Essex, Maryland 21221 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, how, or heart failure. List only one course on each line. Approximata Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in deeth) /Medical ardiovascular disease Examiner Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed physician end the burial-transit Sequentially list conditions, if eny, laeding to immediata cause. Enter Underlying Causa (Disaasa or injury that Initiated evants rasulting in daeth) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 80 USB signed by the e Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No Probably 4 Unknown þ 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? cartificate has b 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa rafarrad to medical exeminer? Be 26. Plece of Deeth (Check only ona) Other: 4 Nursing Homa 5 Anasidence 6 Othar (Specify) 2 1 Yas 2 XNo 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) Certification: Aftar 5 Panding Invastigation 1 Yas 2 No n 24 hours after death.

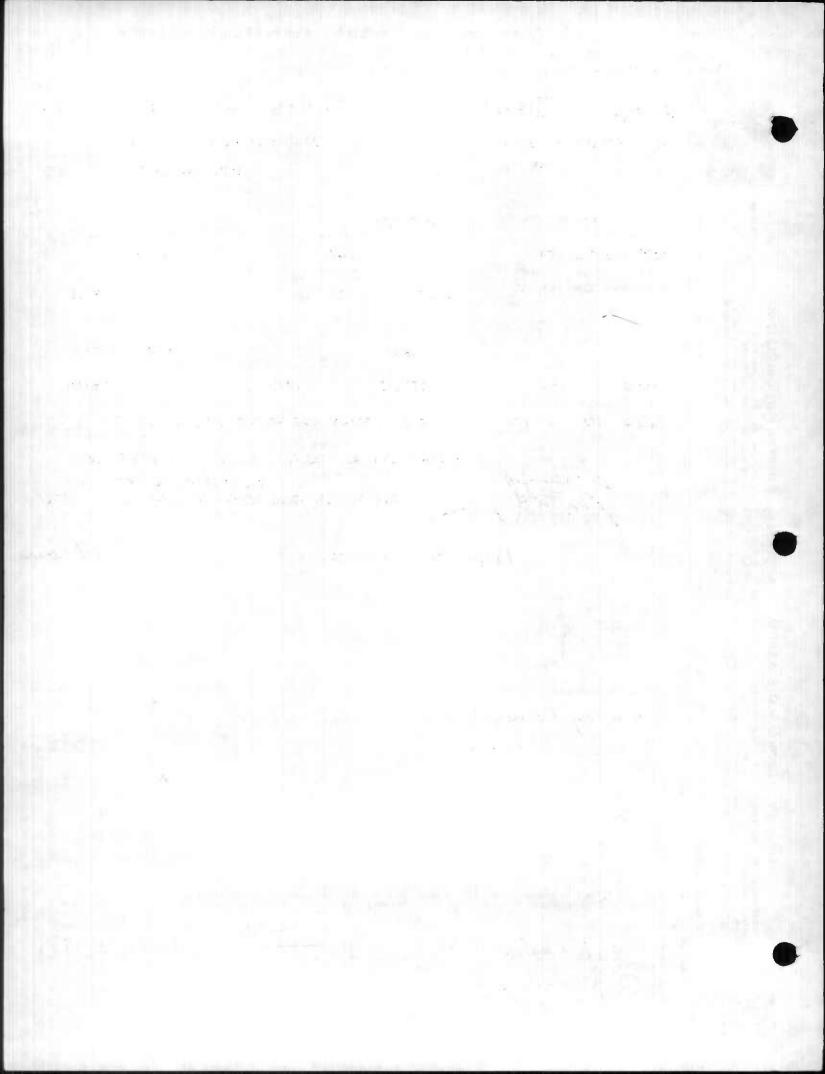
Funeral Director: A pletely filled in by the fi 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Piace of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicida 29a. Certifian 1 🔀 Certifying Phyetcian: To the best of my knowledga, daath occurred at tha tima, deta and place, and dua to tha causa(s) and mannar es atated. (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. To the Within 2 29b. Signature and title of certified 29c. Licanse number 29d. Data signad (Month, Day, Year) D354 30. Name and eddress of person who complated causa of death (Item 23a) (Type, Print) 6918 Ridge Rd. Baltimore MD PFEFFER m, 31. Dete filed (Month, Day, Yaar) 32. Ragistrar's Signatura MAR 09 1999 Registrar

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C. P. 1911 THE PARTY NAMED IN "gramma mental page and the state of the MALE TO THE SECOND STATE OF THE SECOND STATE O

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item: 29c per V.R G-679 3/23/9 State of Maryland / Department of Health and Mental Hygiene 9 07484 Amended #23apt1 perPhyG769 3/9/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** David Joseph David
4a Facility Name (If not institution, give street and number) 2, 1999 illes MARCH 2.00 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY JOHNS HOPKINS HOSPITAL BALTIMORE CITY | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Month, Dev. Year) | JAN. 20, 1926 6. Sex 10 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 219-18-0906 73 Yrs. MD Director Usual Residence of Decedent the Merylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 4523 DRESDEN ROAD 21208 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1Ã Yes 2 □ No If Yes, Give WWI 14. Race - American Indian, 11. Marital Status Biack, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Heelin and Mental Hyglene.
In It flem 27 la marked other than "natural", or ite my or other traumatic avent, in a Maximal Exercise ury or other traumatic avent, in a Maximal Exercise. 1 Never Married Married WWII 1 ☐ Yes 2 X No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) 12 AGENT LIFE INSURANCE 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be HYMAN MAX TILLES MARY LEVIN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ELAINE TILLES / WIFE 4523 DRESDEN ROAD -BALTIMORE, MD 20a. Method of Disposition 20b. Piaca of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or pace. SHAAREI TFILOH CEMETERY 3/3/99 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 an s that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, see the each line. **Physician** /Medical Immediate Cause (Final Aspiration disease or condition resulting in death) PNEUMONIA Examiner Due to (or as a consequence of) Examiner physician end the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): for use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown oronary Artry Disease p 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24a. Was an autopsy Inferction pege 2 s 2 No 1 ☐ Yes 2 ☐ No certificate director. or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No deeth. investigation ofter deeth Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) within 2 To the Complet 29c. License number p-07876 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 MD larch Z. 30. Nerne and a edress of person who completed cause of death (Item 23e) (Type, Print) (nail Berkerblit 32. Registrer's Signature 31. Date filed (Month, Day, Year) State MAR 9 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Ellen Hassell 1999 6:00 P.M. Turner March 6, /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1142 Hewitt Way Baltimore N/A8. Dete of Birth (Month, Dev. Yeer)
Ian. 15, 1915 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Min 1 M 2 F Months Days Hours 84 Yrs. Director 233-28-1213 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Medical Examinations to inclined all 1X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1142 Hewitt Way U. S. A. 21205 by Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mentel Hygiena. ant: if Item 27 is marked other then ' ury or other traumatic event, tra Ma Etementery/Secondary (0-12) College (1-4or 5+) 3rd Grade Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Walter Camp Ella Tinker 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 1142 Hewitt Way, Baltimore, Maryland 21205 Eleanor Bracey (Daughter) 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or page. Holly Hill Mem. Gardens 3/10/99 Baltimore. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 23a. Pert1. Enter the disease or compilitations that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest,

Approximate May 7 Approximete Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Finat · Chronic Obstructive Pulmonary Disease disease or condition resulting in deeth) year Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): ettending physiclan for use es the buria Physician/Medical Due to (or as a consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Edema, Mitral Regurgitation, 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed been Pulmmany Hypertensian has 1 Yes 2 No 1 Yes 2 No this cartificate al or Attending Physician: T s after death. ii Director: After this cartificat ad in by the funeral director, p 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2₺ No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner steted.

filed within 72 hours after deeth with

the death certificate be appointed

The law requires

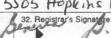
Division of Vital Records, P.O.

Baltimore, Maryland 21215-0020

State Registrar 31. Date filed (Month, Day, Year)

iller Chutro

29b. Signature and fitte of certifier



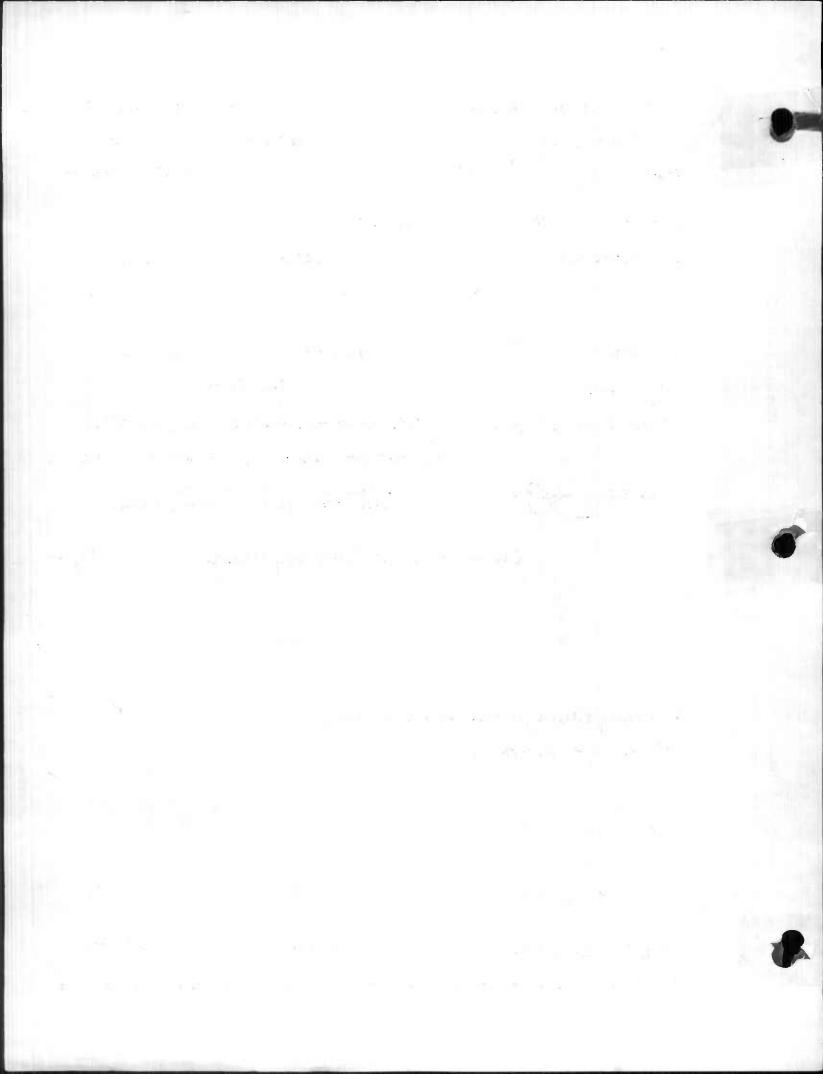
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Cileen Christmas, MD 5505 Hopkins Bayyew Circle, Baltimore, Mary land 21224

29d. Date signed (Month, Day, Year)

March 81

29c. License number

D 51185

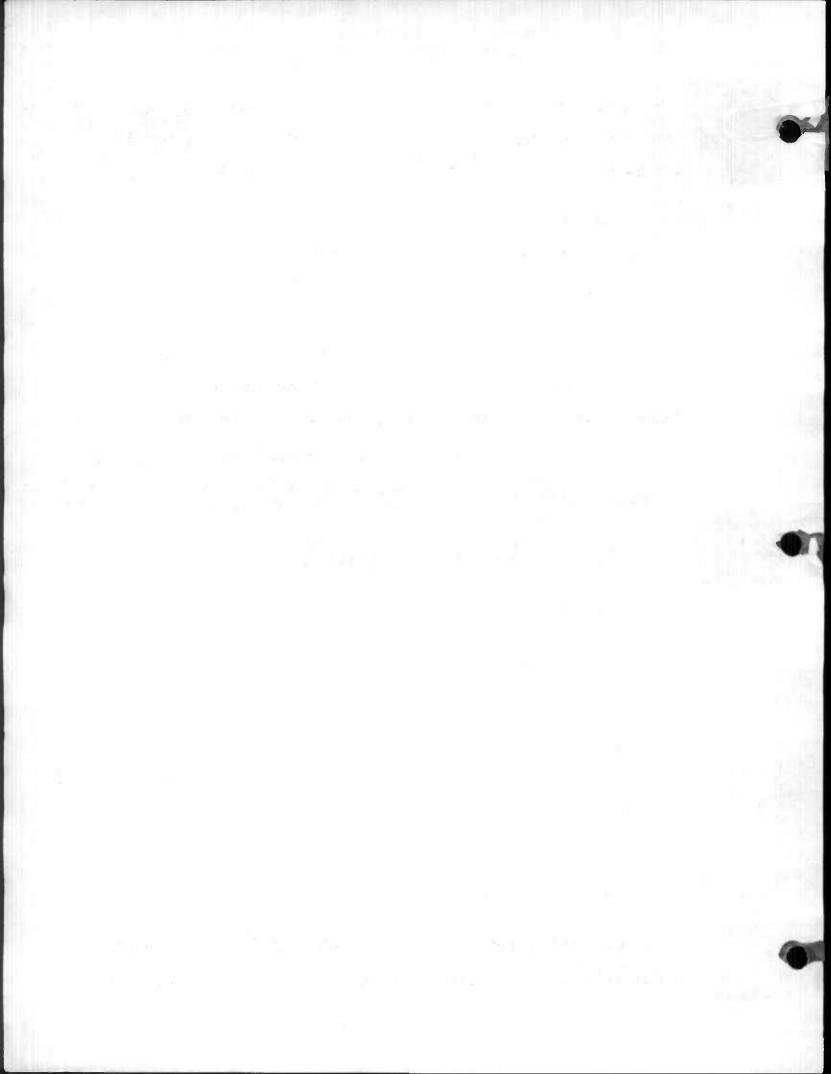


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Philip L. Turnbaugh, Sr. 1999 MARCH 12:05 PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4230 Littlestown Pike Westminster Carroll If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 21, 5. Social Security Number If Under 1 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Days 218-16-2403 73 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4230 Littlestown Pike 21158 USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or item any injury or other traumatic event, the Mental once. Black, White, etc. 1 ☐ Never Merried 2 🕅 Married 1 ☐ Yes 2 ☐ No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Adams Co. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Turnbaugh Bertha Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances E. Turnbaugh - wife 4230 Littlestown Pike, Westminster, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 (Burial 2 Cremation 3 Removal from State Meadowridge Memorial Park 3/05/99 4 ☐ Donation 5 ☐ Other (Specify) Elkridge. Md. 22. Name end Address of Fecility 21. Signature of Funeral Service Licen-Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md. 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner as a consequence of) Examiner physician end s the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 80 ettending i been signed by the e should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No g 24b. Were autopsy findings available prior to Completed 24e. Wes en autopsy performed? completion of cause of death? hes **pege 2** 1 Yes 2 No 1 Yes 2 No certificate Attanding Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death Certification: 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Natural 2 Accident 5 Pending investigation deeth. 1 Tes 2 🗆 No spital or Attandi nours after deeth neral Director: A filled in by the f 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 51705 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) MALCOLM DQ WESTMINSTER M-PANSURINA, MD 419F 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 9 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 7487 State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month March 6, 1999 **Physician** 5:32 P.M. SARAH JANE THOMAS /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 21 Sherwood Ave. Pikesville Baltimore If Under 1 Year | if Under 24 Hrs. 8. Dete of Birth (Month, Dey. Year)
Jan. 17, 1922 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (Stete or Foreign **Funeral** Deys Months Hours 1□ M 2\ F 215-14-5200 Balto. Md. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Pikesville 1 Yes No Director Md. Baltimore 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? USA 21 21208 Sherwood Ave. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1♥ Yes 2□ No If Yes, Give Year or Detes: 14. Race - American Indien, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: White Specify: by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Drug Store 8 th Grade permit. Pages 1 and 2 should be file Department of Heath and Mantal Hy Important: I fem 27 is marked other any Injury or other traumatic event 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Charles Alder Pauline Knott 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) James B. Thomas 21 Sherwood Ave. Pikesville, Md. 21208 (Husband) 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State DXBuriel 2 Cremetion 3 Removel from State 3/9/99 Mays Chapel Cemetery Lutherville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road and ELINE FUNERAL HOME Reisterstown, Md. 21136 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician mediate Cause (Final disease or conditio resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use gafitribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2€ No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 1 □ Vas 2 □ No 2546 25. Was case referred to medical 26. Place of Death (Check only the) 88 Other: 4 Nursing Home 5 PAssidence 6 Other (Specify) 2 1 Yes 2010 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner pPDeath 28b. Time of 28d. Describe how injury occurred Certification: 1 Elevatural 5 Pending 1 Yes 2 No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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Maryland 21215-0020

Baltimore,

rthan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

DHMH 16 Rev 6/95

State Registrar

29b. Signature and title of certifier

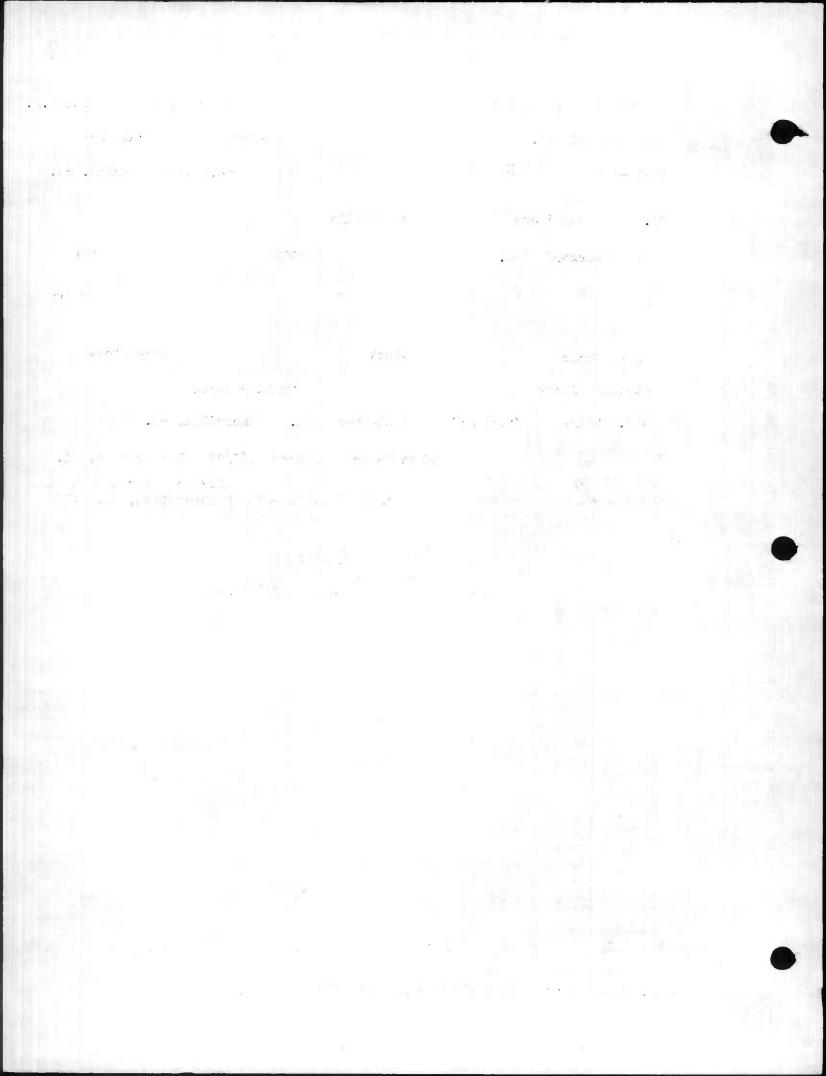
Buller DD.

30. Name and address of person who completed cause of death (frem 23s) (Type, Print) Andrew Becker

15 Walker Ave., Pikesville, MD 21208

29c. Lipense number

29d. Date signed (Month, Day, Year)



certificate be

Physician

* /Medical

Examiner

Funeral

Director

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permit. Peges 1 and 2 should be filed within 7 Department of Heelth and Mentel Hygiene. Important: If Item 27 is merked other than "re any injury or other traumatic event, the Med blace.

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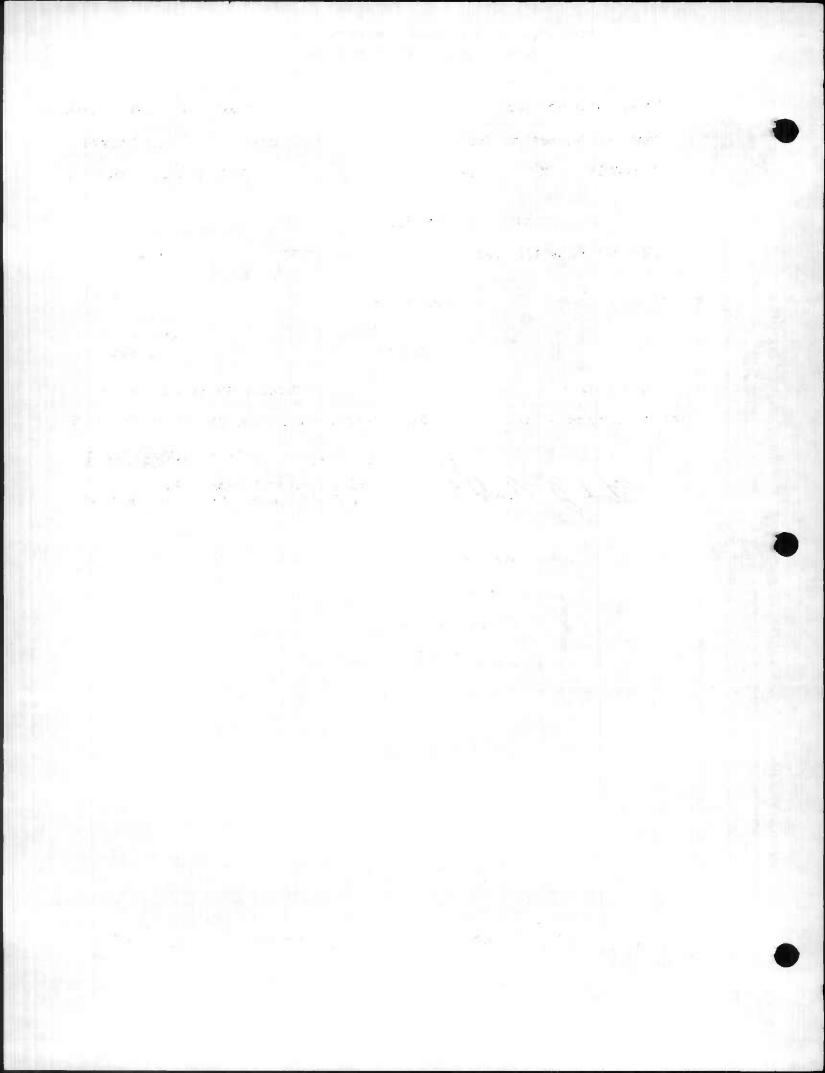


12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number D-18809 MD

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Md 2 1401

104 Ridgely Barbara 31. Dete filed (Month, Dey, Year)



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aminer	4e Fecility Nem		HUSPI	A .					MORE	,	4c. County of Death	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1999 Margaret Fadean VanTasse1 MARCH 7, 5:10am 4b. City. Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Augsburg Lutheran Home Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, APR 10, 9. Birthpleca (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. lest birthdey) 1907 Months Days 1□ M 2 T 91 057-10-7391 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Baltimore 10g. Citizen of What Country? 10f. Zlp Code 10e Street and Number 6811 Campfield Road 21207 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No White Specify: Specify: 3 ₩ Widowed 4 Divorced Year or Detes 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Public Eiementary/Secondary (0-12) College (1-4or 5+) English Teacher School System 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Cecil Pleasants Lenora Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 5642 Kavon Ave. Baltimore, MD 21206
Date | 20c. Location - City or Town, Stete Mary V.T. Murtha/daughter 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremetion 3 ☐ Removal from State Metro Crematory, Inc. 03/08/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Cremation Society of Maryland, Inc. NcDonald or complications the st only one Davidune 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. Approximate Interval Between Onset and Death Immediete Cause (Final nours disease or condition resulting in death) Due to (or es e consequence of) Due to (or as a consequenca of): Due to (or as a consequence of). 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician 7Medical Examiner

and Il-transit

attanding physician (for use as the burial

signed by the a

peeu has je 2 s certificate has director, page 2

the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifica npletely filled in by the funeral director, i

The law requires that the death certificate be axecuted

P.O. Box 68760.

Division of Vital Records,

Physician

/Medical

Examiner

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Funerai

by

Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/Medical Examiner þ Completed Be Certification: To

edicai

29a, Certifier

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Wes case referred to medical examiner? 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Natural 5 Pending Investigation Injury 2 Accident 3 ☐ Suicide

6 Could not be 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

2 X No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Baltimore,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) 29c. License number 29d. Date signed (Month, Dev. Year)

29b. Signature and title of certified elice

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Deborah I. Pierce, 7220 ParkHeights Ave. M.D.

and manner stated.

31. Dete filed (Month, Dey, Year)

MAR 0 9 1999

32 Registrar's Signature

State Registrar

To the within 2 1.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth VION PARIS MARCH PAULA 12:02AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMURE CIT TOPKI AL SHELLING STATE OF THE STATE HUSPIT 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthpleca (Stete or Foreign Country) 1□M 2⊠F Months Deys Hours Yrs. 215-12-0487 March 1, 1914 Maryland Usuel Residence of Decedent 10e Stele 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 717 Maiden Choice Lane #401 21228 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Spring Grove Hospital Secretary 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Charles duBreuil Mildred Richardson 19a. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Bonaventure E. vonParis-Husband 717 Maiden CHoice Lane #401, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremation 3 □ Removal from Stete St. Alphonsus Cemetery 3/10/99 Woodstock, Maryland 4 Donation 5 Other (Specify) 21. Sonature of uperal Service Licensee 22. Name end Address of Facility Witzke Funeral Homes, 630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth 2 DAYS immediate Ceuse (Finel CARDIOVASCULAR COLLAPSE diseese or condition resulting in deeth) Due to (or es e consequence of): EMBOLISM PULMONARY Due to (or as a consequence of) Due to (or es a consequence of): Pert ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes 2 | No

Physician /Medical Examiner

physician ar s the bunel-to

signed by the e

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SHIS funeral

After

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Ne Funeral Director: Af plately filled in by the fu

within 24 ho To the Fune completely fi

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The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Certification:

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permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Haalth end Mentel Hygiena. Important: If Itam 27 is marked other than "natural", or itams 23s or 28s-f show ship injury or other traumatic avent, the Mexical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

ATRIAL FIBRILLATION MITRAL STENOSIS

24b. Were autopsy findings evailable prior to 24e. Wes en eutopsy completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

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27.	Manner of D	eth	
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investigation 6 Could not be determined 28e. Placa of Injury - At home, term, street, factory, office building, etc. (Specify)

1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

29e. Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner stated.

29b. Signeture end title of cartifier

29c. License number REC-000 29d. Date signed (Month, Day, Year)

NRRCh 6, 1999

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) JOHNS HOPELES ABUTAHER M. JAHIA, MD

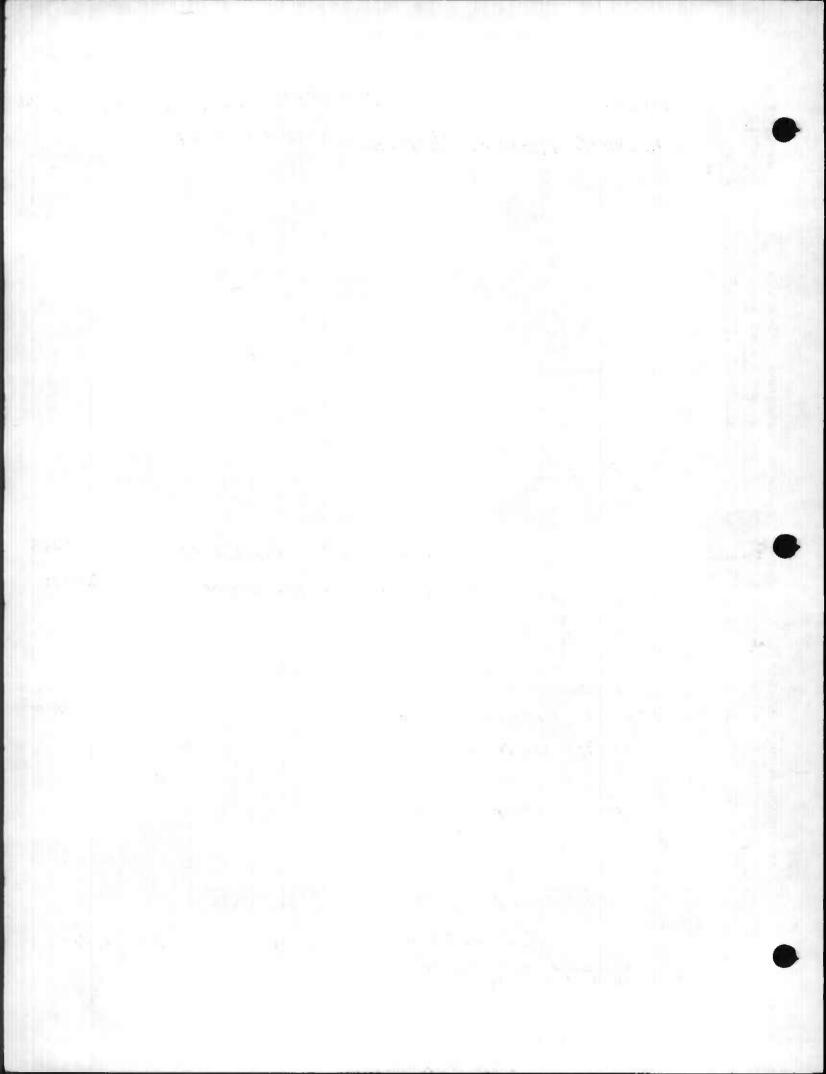
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31. Date filed (Month, Day, Yeer) MAR 9

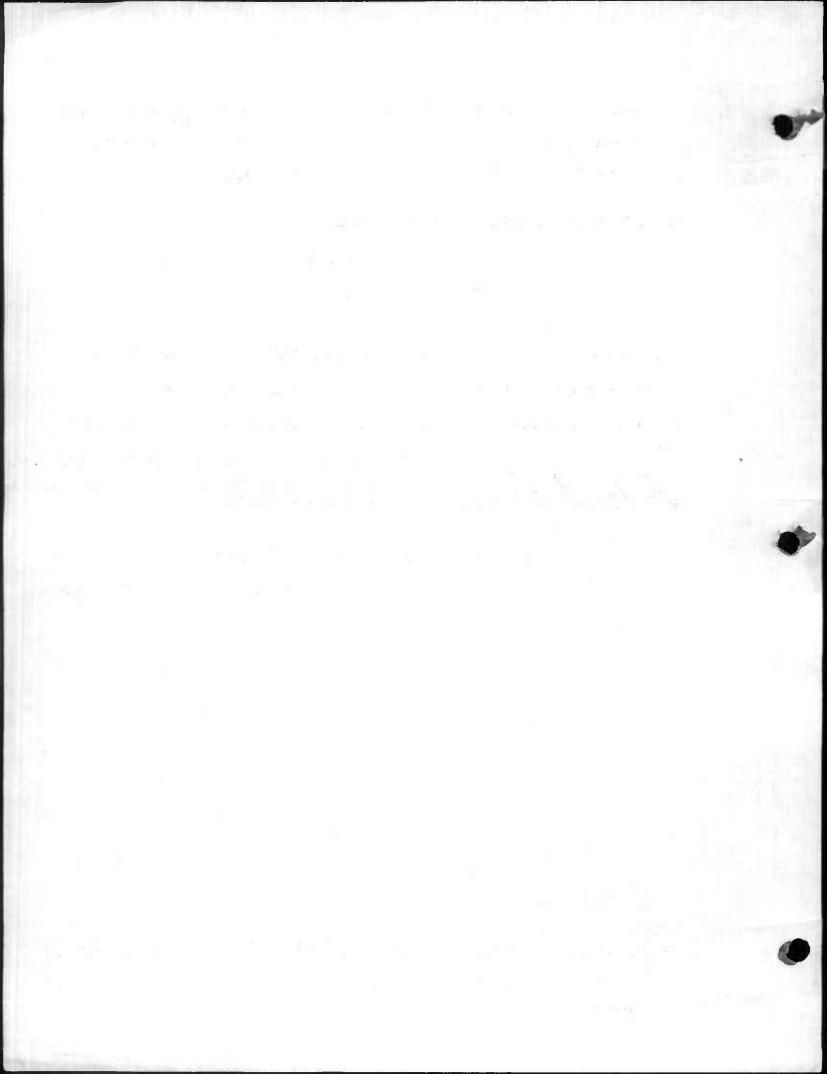
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Hosp. BANT



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Director														10d. Inside City Limits 1 ☐ Yes XXNo
Director		MARYLAND ANNE	ARUN	NDEL	(GLEN	_							
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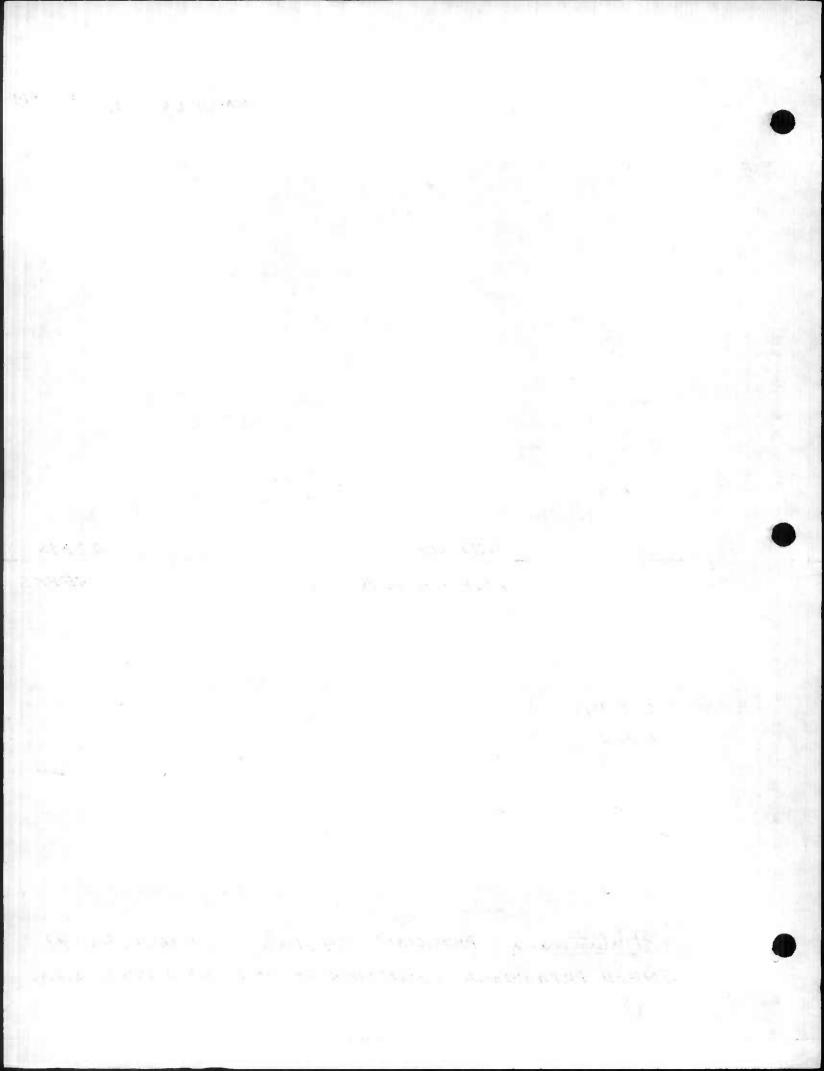
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 07493 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** Month Year 6:15 PM MARCH Thomas Henry Wheeler 1999 03 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/a If Under 24 Hrs. 6. Sax 1 M 2 □ F If Under 1 Year 5. Social Sacurity Number 8. Date of Birth (Month, Dey, Year) May 10, 1922 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Days Delaware 76 Yes Director 213-14-7605 Usual Rasidance of Dacadent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1K Yas 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Herna 23a 3425 Dudley Avenue 21213 Funeral U. S. A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marilel Status 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 "natural", or 1 Yas 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorcad White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Health end Mental Hyglene. Important; if item 27 is marked other than ** any filury or other traumetic avent; the Mad pings. Elementery/Secondary (0-12) College (1-4or 5+) 5th Grade Laborer Baltimore City 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Thomas H. Wheeler Lena M. Woodzer 2 19e, Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Robert Unkle (Friend) 3425 Dudley Avenue, Baltimore, Maryland 21213 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlel 2 ☐ Cramation 3 ☐ Ramoval from Stata Green Mount Crematory 3/5/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetura of Funaral Sarvice Licenses 22. Name and Address of Facility Schumuner Funeral Home Inc. trudo 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Entar the disasse or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition rasulting in death) /Medical SEPSIS 2 DAYS Examiner Due to (or as a consequence of): Physician/Medical Examiner WEEKS PNEUMONIA sician and bunal-transit Sequantially list conditions, if any, laeding to immadiate causa. Enter Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): nding physician use as the bune Box 68760 The law requires that the death certificate be Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No COPD Records, py CRI 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24e. Was an autoosy 1 Vac 2 Dillo 1 Yes 2 No Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, I 25. Was casa refarred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 ☐ Impatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 D Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29e. Certifiar (Check only one) 29b. Signatura and titla of certifian 29c. License number 29d. Dete signed (Month, Day, Year) ullumana : PHYSICIAN D47123 MARCH. 03, 99 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) JOJEPH PUTHUMANA, UNION MEMORIAL HOSP. BALTIMORE 21218. 3. Registrer's Signatura 31. Data filed (Morith, Day, Year) State MAR 0 9 1999 merra

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Dey 25 1999 FEB. 8:13 A.M. JULIA WILLIAMS 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Deeth 1300 WASHINGTON BLVD. APT 114 BALTIMORE If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign 1□ M 2∰ F Hours Deys Months S.C. Yrs 93 248-20-7869 Usual Residence of Deceden 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 Yas 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 U.S.A. 1300 WASHINGTON BLVD. APT. 114 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U.S. Armed Forces? 14. Race - Amarican Indian, Bleck, White, etc. 1 ☐ Yas 2 ⊞ No 1 Never Married 2 Married 1 ☐ Yas 2 # No Specify: Specify BLACK 3∰ Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER HOME 10 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) OLIVIA EADDY JOE EADDY 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 1227 S. CAREY ST. BALTIMORE MD. 21230 JULIA HUBBARD 20b. Place of Disposition (Name of cametery, crametory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta 1#Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) LANSDOWNE, MD. 3/4/99 ZION CEMETERY 21. Signeture of Funerel/Service Licenses 22. Name end Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE, MD.21217 23a. Part1. Enter the disease, or complications that coused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervet Between Onset and Deeth CHROLOVASCY LAR Biseuse Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or tnjury Due to (or es e consequence of): thet initiated events rasulting in daeth) Last Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 Yas 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Dete of tnjury (Month, Dey Year) tnjury et Work? 28d. Describe how Injury occurred 28b. Time of

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or thams 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygians. Important: if item 27 is merked other than "natural", or its any injury or other traumatic event, the Medical Examina

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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physicien end s the buriel-trans 98 0 6 bengis d be del peen hes page 2

certificate director, this the funeral ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: Atter ti in by t

Division of Vital Records, P.O. Box 68760

Aq Completed Be To

edicai

1 Naturat

2 Accident

3 Suicide

29a. Certifier

4 Homicide

within 2

Examiner that the death certificate be executed Physician/Medicai Physiclan: Certification:

> 29b. Signeture end title of certifian V ansort

5 Pending Investigation

6 Could not be determined

29c. License number 020040

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

700 WASHINGTON BLVD. BALTIMORE, MD. 21230 31. Dete fited (Month, Day, Yeer)

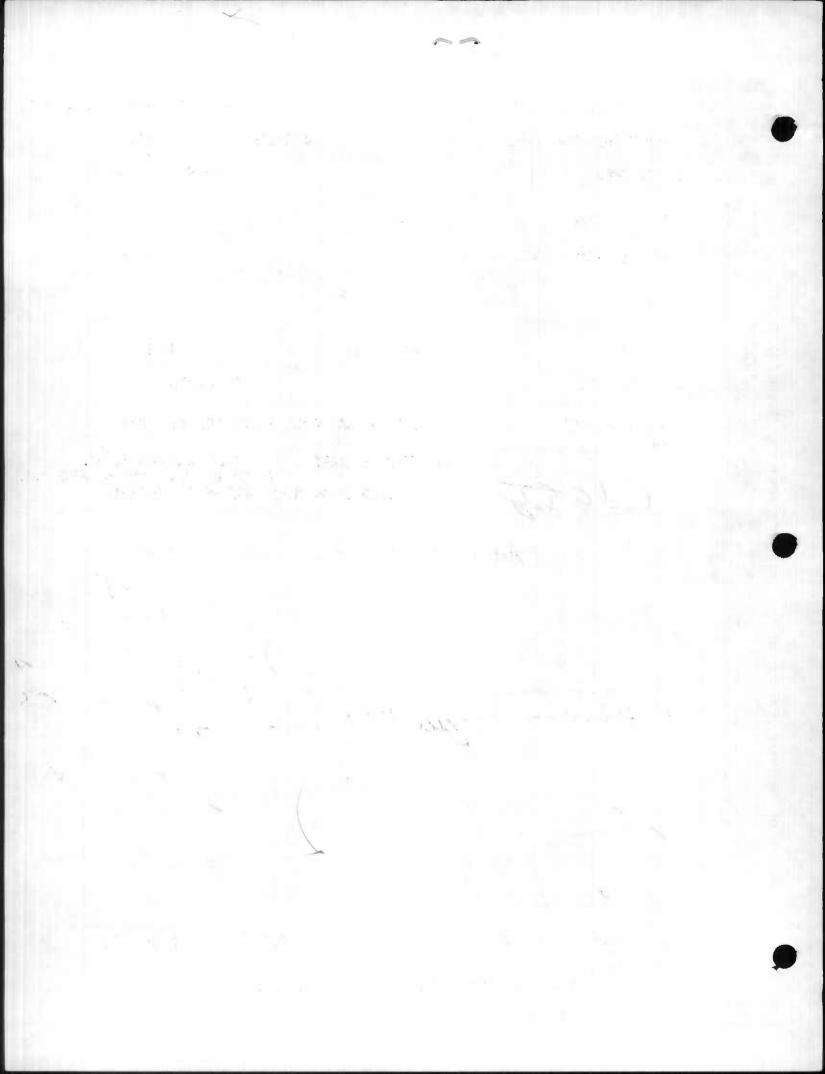
JAMES

1 Yes 2 No

State Registrar

MAR 0 9 1999

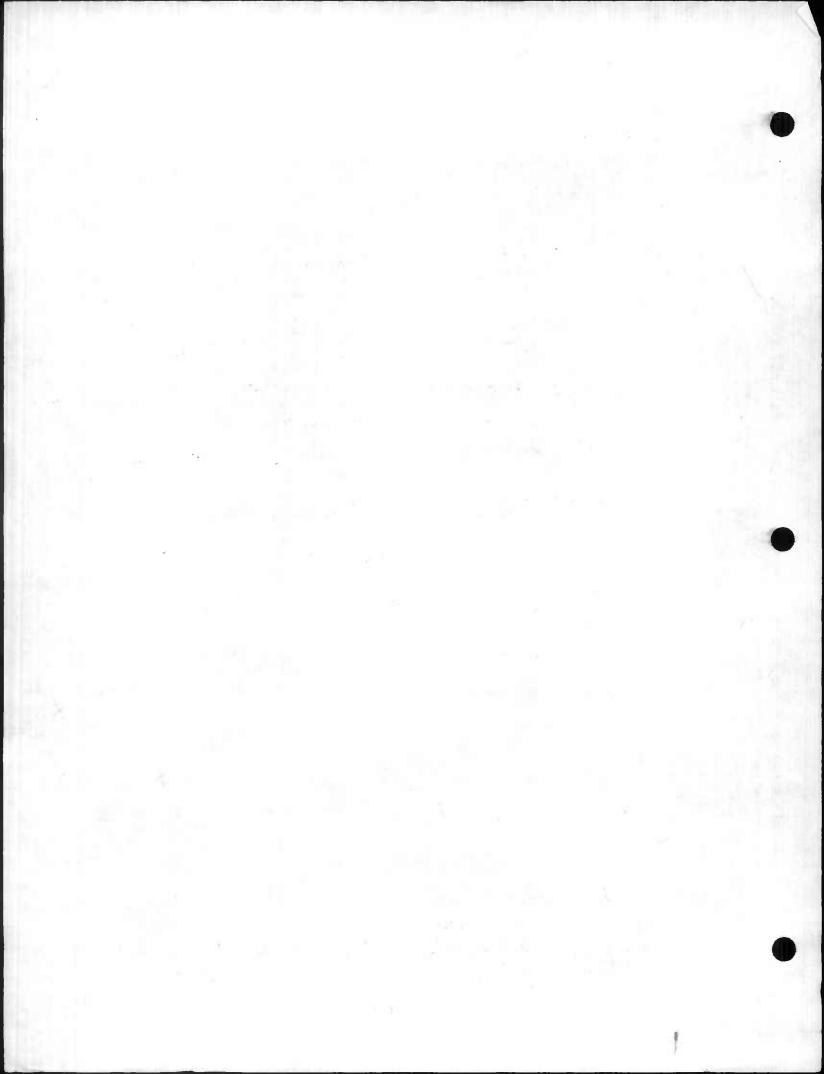




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State of Maryland / Department of Health and Mental Hygieneg 9 071, 95

			Cer	tificate o	f Death	R	eg. No.	07493		
Physician /Medical Examiner	Decedant's Neme (First, Middle, Last			2. Dete of Deal Month	Day Y	3. Tima of Death				
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	Johns Hopkins		tona tratato do 1	If Under 1 Ye	Baltin			A		
Funeral Director	5. Social Security Number 6. Se 225-38-8203	7. Aga (In yrs.	Yrs.	Months De		(Month, Dey 03-17-	8. Dete of Birth (Month, Dey, Year) 03-17-35 9. Birthplaca (Stat Country) V			
Man Man	10a. Stete 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limit		
Mary Mary Tor	MD NA	Ва	altimo	re				X⊠Yes 2 No		
ifier death with the Mark fame 23e or 28e-f sines roughed in the modified Funeral Director	10e. Streef and Number 1628 Lochwood	1	10g. Citizen of What Country? USA							
within 72 hours after death with the Maryland ene. Then "natural", or items 23a or 28a-f show the Weddel Examiner must be notified at empleted by Funeral Director	11. Meritel Status 1 Nevar Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yas ※[X]No If Yes, Give Yaar or Dates:	Forces? If Yes, specify C as X(X)No Give 1 □ Yes 2(2)N			pecify Yes or No- o Rican, etc.)	Bleck,	American Indien, White, etc.		
2 hou	15. Decedent's Edu	ucaflon	16a. Deced	lent's Usual Oc	cupation		16b. Kind of Busi			
vid be filed within 72 ho Mental Hygiene. Irked other than "naturi atic avent, the Medical To Be Completed	(Specify only highest grad Elementary/Secondery (0-12)	le completed) College (1-4or 5+)	(Give life. L	kind of work do DO NOT use ret	na during most of wor ired)	king				
- 'E - W	7th Grade	NA NA	Cons	tructi	.on		Brick	Mason		
tal Hyginal Hyginal A other avent, II	17. Fether's Neme (First, Middle, Last)	BUENTS			18. Mother's Ner	ne (First, Middle, I	le, Maiden Surnema)			
permit. Pagas 1 and 2 should be filed. Department of Health and Mental Hyg important: if item 27 is marked other important: other traumatic avent, ones. To Be C	John Randolph	n Weddingto	on		Estell	.e :	Jolly			
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and and in 27 In a 27	Florence Wedd	dington	1628	Lochy	rood Road	Baltin	nore, M	aryland		
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he at ed fo	Pert If. Other aignificant conditions con	ntributing to death but not res	sulting in the ur	e underlying cause given in Part f. 23b.			Did tobacco usa contributa to the cause of death			
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signer the document of be d					4	24a. Wes a	n autoness	24b. Were eutopsy findings		
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has has mpi							1	of death?		
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5 × 5 0 5	29b. Signeture end title of certifier	0			ensa number			(Month, Day, Year)		
	Coaney	Krook	20	D	43636		mbrch	5, 1299		
0	30. Neme and address of person who co	ompleted cause of deeth (Iter	m 23a) (Type, I	Print)	47676 Dr. Rodn	OV Proc	ke MD	1		
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State	31. Dete filed (Month, Day Year)	1000 32. Regisfrar's Signa	eture	1 1	,)			
Registrar	Turun J	TOUCH TO THE	/	J. 61	30.11					

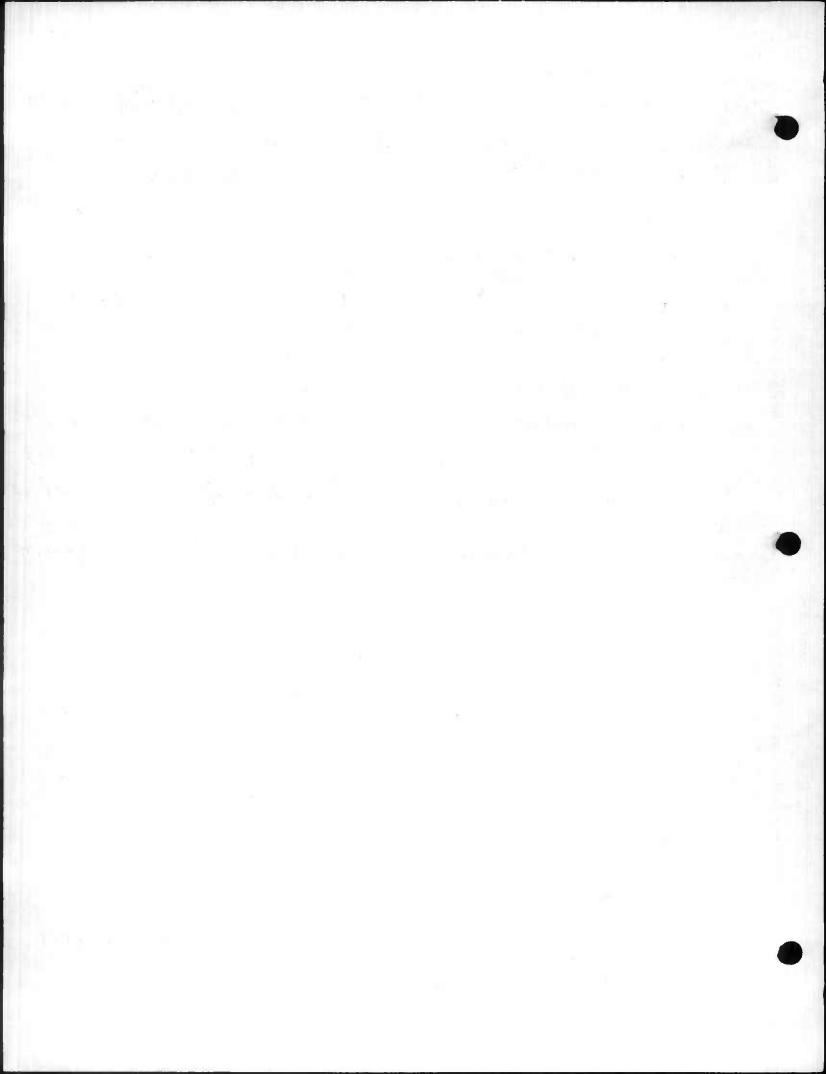


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 7 1, 9 6 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death RENE WILTZ Month Day-It de **Physician** 9-15AH THELHA Harch /Medical 4e. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto Center JAMARITAN 5. Social Security Number UTSING If Under 1 Year | if Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months 84 20 6205 Director Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Example: must be notified at BALTO Md N.A MYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Dane 431 Lang 4.5.A 21212 nortra Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 11. Marital Status pernit. Peges 1 and 2 should be filed within 72 hours efter. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel may injury or other traumatic event, the Modiful Engine. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WITE HOUSE 124 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be JOHN SON TRENC ALFREd SAKEr 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) LINDEN AVE Balto. mx 21206 DELORES 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State ANNE ARUNDEL 3/10/99 Mrt. CALVARY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility 304h neph court acks 23e. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Pertastatie cancer Not Known /Medical Immediate Ceuse (Final diseese or condition resulting in death) **Examiner** Due to (or as a consequenca of) Examiner the death certificate be executed physician and the bunal-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequenca of): P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): ed by the attending detached for use es Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signed by I 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, þ cate has been signated by page 2 should b 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No After this 27. Manner of Death 28e. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: Attanding 1 Natural 2 Accident 5 Pending investigation Injury To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Affe completely filled in by the fun. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. 29d. Date signed (Month, Dey, Year) Karch 5th 19 29b. Signature and title of certifier 29c. License number K. purdiemi D 30661 well 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 REES HK TRIPURANEW) 5601 Lock Raban Blod, Baltimado, Ha 31739 Blid, Baltimole, Md - 21239 31. Date filed (Month, Dey, Yeer) 32. Registrer's Signeture State 1 CAMA 1999 Registrar MAR 9

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Williams **Physician** 100 Va larch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Saltimore Hospital inthday) If Under 1 Year Hopkins Johns If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) 6. Sex Months Days Hours Min. 1□ M 2K F 01 109 05 Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits N.A Bay 16 16 Yes 2 No Director Item 27 is marked other than "naturel", or items 23a or 28a-f other traumatic event, the Medical Examples must be notified 10e. Street and Number-10f. Zip Code 10g. Citizen of What Country? 24 231 Funeral deeth 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Marital Status 14 Bace - American Indien Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or item 1 Yes 2 No if Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2€ No Specify: Black P 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domes Tic 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be JOHN Henry DANGERS ISAbelle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Kway Ba(ts. MC) 21216 20c. Location - City or Town, State, 293/ Surym Jales KICHDUT I hom AS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 3/12/19 iny injury or 22mg arrany 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 30471 Lacks 23a. Part 1. Enter the disease, or complications that cellsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CEREBRAL ACCIDENT VASCULAR Examiner Examiner MONTHS FIBRILLATION requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): and buriel-trer YEARS. Division of Vital Records, P.O. Box 68760 physician Physician/Medical the Due to (or as a consequence of): SE esn Por Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown MYPERTENSION signed I à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? page 2 s 2 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: 25. Was cese referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1□ Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending Investigation after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Certifier Medical (Check only one) To the P within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 000 €5

State Registrar

MAR 9

31. Dete filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

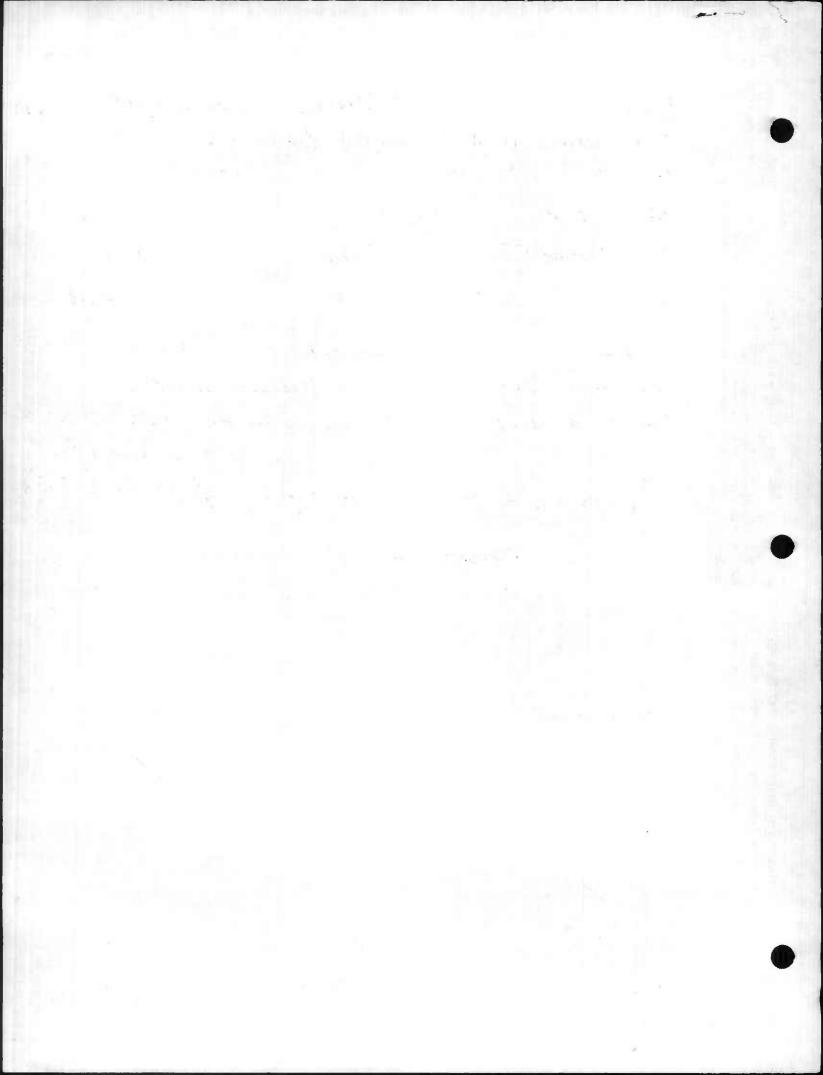
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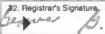
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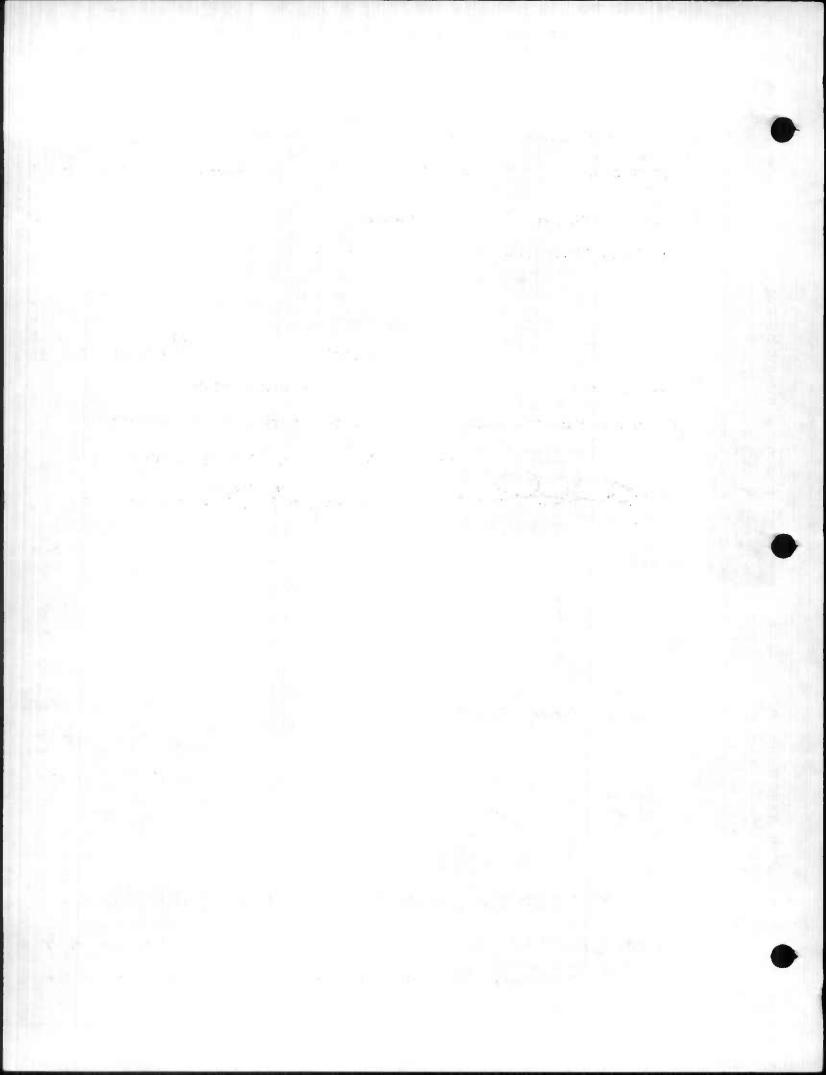
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth **Physician** 11:40 PM XINTAS SYLVIA MARUI 07 1999 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOSPITAL BALTIMORE SAMARITAN n/a | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | March 2 1918 9. Birthplace (State or Foreign Country) West Virginia 5 Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months 10 M 20 F Yrs. 213-38-6106 81 Director Usuel Residence of Decedent the Meryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21286 USA 7 Airway Circle, Apt. 4B death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Xo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: White þ 3 □Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit Pages 1 end 2 should be filed within 7 Coparant of Health end Mentel Hygiens Important if flem 27 is marked other than "n my injury or other traumetic event State College (1-4or 5+) Elementary/Secondary (0-12) Unemployment 12 Administration 18. Mother's Name (First, Middle, Malden Surneme) 17. Father's Name (First, Middle, Last) Rodonthi Politis Mike K. Melis 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1101 Hampton Garth, Towson, MD 21286 Daphne R. Salsberg/daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Moreland Memorial Park 3/11/99 22. Name and Address of Facility 21. Signature of Funy Lemmon Funeral Home 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line.

Appropriately. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS 15 DAYS disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner INFECTION URINARY TRAC? The law requires that the death certificate be executed attanding physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 0 the detached signed by t 1 Yes 2 No 3 Probably 4 Unknown ٦ RENAL FAILURE ACU78 Records, P 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy been : page 2 hes 1 Yes a⊠No 1 ☐ Yes 2 ☑ No certificate Division of Vital or Attending Physician; director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) L_o 1 Yes a No Unpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending Investigation within 24 hours after death, To the Funeral Director; Af completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) illed in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 Kurahmoha MARCH 08, 1999. P-12562 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPIDOR, BARILMORK Am K MATTINGAA

State Registrar 31. Date filed (Month, Day, Year) MAR 0 9 1999





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Younkin 1999 01:26 5 Lois Μ. March /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore N/A St. Agnes Hospital 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthpiace (Stete or Foreign Country) **Funeral** 10 M 20 F Months Days Hours 79 218-07-7637 Yrs. June 22, 1919 Director Maryland Usual Residence of Deceden the Maryland 10c. City, Town or Location 10e Stete 10h County 10d. inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Hanover Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7548 Old Telegraph Road 21076 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Maritel Status permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exemp 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County College (1-4or 5+) Elementery/Secondary (0-12) Art Teacher Public Schools 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Rev. Louis H. Mietzsch Daisy E. Patrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 5275 Five Fingers Way, Columbia, MD Robert A. Younkin (son) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Ø Buriai 2 ☐ Cremetion 3 ☐ Removel from State Holly Hill Mem'l Gardens 3/6/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signeture of Funeral Servica Licensee Schimunek Funeral Home, Inc. llen 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21236 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner ue to (or as e consequence of): Examiner Acute RENAL Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68768, Pulmonory Distance Chonic Olstrictive physician Physician/Medical tha Due to (or es e consequence of) 50 Angina 10015 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably Unknown Hyperhipidemia þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Was en eutopsy performed? Completed After this certificate has or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 28c. Injury et Work? 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homleide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Caton Aur Bulhmore City MO 900 37. Registrar's Signature

MUTYlow

horn officer

mo 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

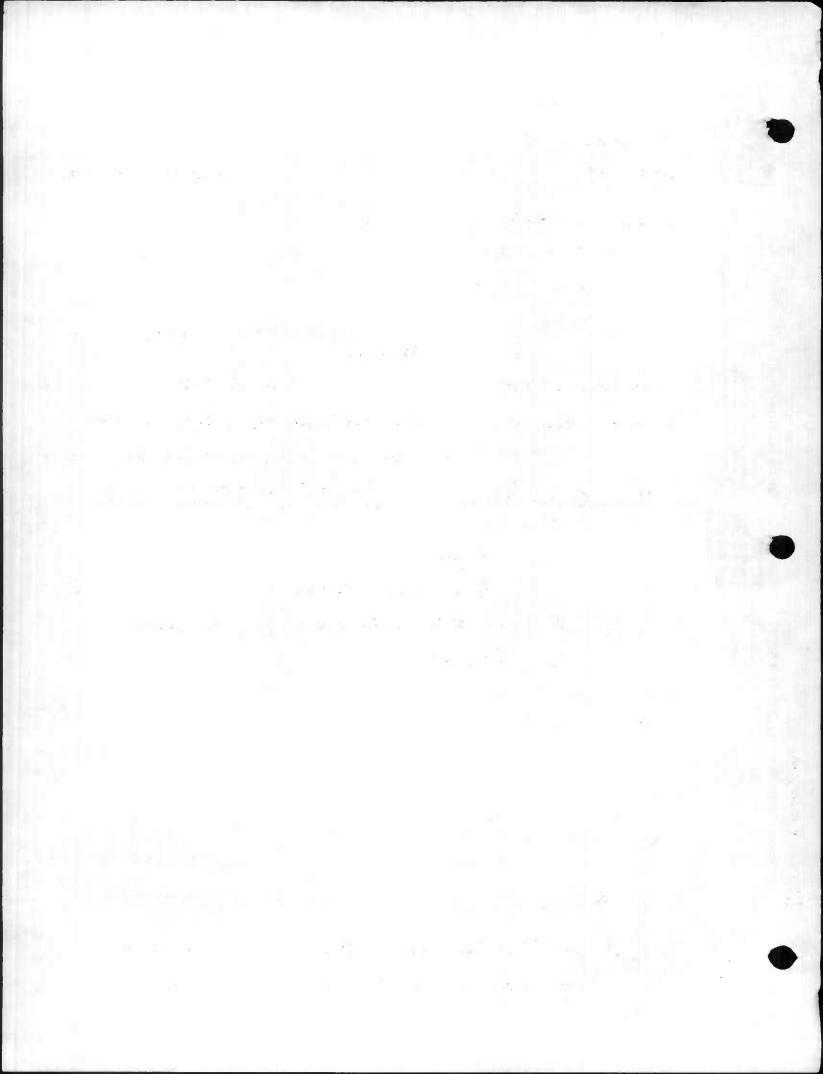
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		Certi	ficate of Death	Re	g. No.	1300	
THE REAL PROPERTY.	1. Decedent's Name (First, Middle, Last)			2. Dete of Death		3. Time of Death	
Physician /Medical	Edward J.	Zε	ledonis Sr.	March	8 ^{ay} 19 9 ^{ay}	4:00 AM	
Examiner	4a Facility Name (If not Institution, give street and number) Eastpoint Rehab & Nurs	sing Cente	4b. City, Town, or Eastp		4c. County of Deeth Baltimo	re	
Funeral Director	205-03-5969 1\\ M 2□F		f Under 1 Year If Under 24 Hrs Ionths Days Hours Min.		Year) 9. Birth	piace (State or Forei ntry) nsylvani	
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locat	ion			10d. Inside City Limit	
-f show	Md. NA	Baltimor				tv∑ Yes 2□N	
a or 28s-f show	10e. Street and Number		10f. Zlp Code	10	g. Citizen of What Cou	ntry?	
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by	11. Maritai Status 1 □ Never Married 2 □ Married 3 □ Millowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ N If Yes, Give Yeer or Dates:	°1946 15. Wa	s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puer	pecity Yes or No- to Rican, etc.)	14. Rece - Americ Black, White, Specify: Wh		
natural', noina Exe leted by	15. Decedent's Education (Specify only highest grade completed)	16e. Deceden	t's Usual Occupation d of work done during most of wo NOT use retired)	rking 1	6b. Kind of Business/In	dustry	
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other the		NA Maintenan		i C me (First, Middle, M	Crown Cork & S		
Mental H irked out atic ever	17. Father's Name (First, Middle, Last) John	Zaledonis				ilonis	
Marked marked matic e	19a. Informent's Name/Relationship (Type, Print)		Address (Street and Number or R				
th and	Edward Zaledonis (SON)		S. Bend Rd.				
if Health and Mental Hygine and the other treumatic event,	20e. Method of Disposition	20b. Piece of Dispositi cemetery, cremat			Oc. Location - City or T		
y or	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)		eart of Jesus		oundalk,	Marvland	
Department (Important: If any Injury or	21. Signature of Funeral Service Licensee		ame and Address of Fecility W. Dabrowsk				
De La Cara	DA 1000		W. Dabrowsk 1005 Dundal				
physician and the buriat-transit and address Examiner	resulting in death)	Due to (or as a conseque rely rely rely rely rely rely rely rely		amles	disen		
phys the edic	resulting in death) Last	Se to (fr as a consequent	nce of):		1		
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s been si 2 should pleted				24e. Wes er perform	ned?	Vere autopsy finding vallable prior to completion of cause i death?	
page Orm				1□ Ye	s 20 No 1	Yes 2 No	
s certificate he director, page	25. Wes case referred to medical examiner?		26. Place of De	eth (Check only one	e)		
	1 Yes 2 ☐ Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatient	3□ DOA Other: 4 Denursing	Home 5 Reside	nce 6 Other (Speci	ify)	
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within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Inju building, etc	ry - At home, farm, street . (Specify)	, factory, offica	28f. Location (Str. City or Town,	on (Street and Number or Rural Route Number, Town, State)		
24 hours Funers letely fille	29e. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medicat Examiner: On the basis of and manner stal	examination and/or inves	ccurred at the time, date and plac tigation, in my opinion, deeth occ	e, and due to the ca urred at the time, da	use(s) end manner as ite and place, and due	stated. to the ceuse(s)	
vithin Sompl	29b. Signeture end title of certifier		29c. License number	29	d. Date signed (Month)	, Day, Year)	
> 0	1 Aguar	MiD	D 31464		3/9/99		
	30. Name and address of person who completed cause of de	eath (item 23a) (Type, Pri		ech 12d 1		21221	
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